

1041
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN RURAL 11 months and 22 days		d. STREET ADDRESS 810 5th St., N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herman Middle E. Last Adams		4. DATE OF DEATH Month 1 Day 29 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months - Days -	IF UNDER 24 HRS. Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locksmith		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Adams	
14. MOTHER'S MAIDEN NAME Minnie Crawford		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1917 - 1918	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH 6 days 2 yrs.,
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced - 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/7 , 19 58 , to 1/29 , 19 59 , that I last saw the deceased alive on 1/29 , 19 59 , and that death occurred at 11:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 1/29/59 ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale, Md. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 2/2/59	22c. NAME OF CEMETERY OR CREMATORY Dist. of Columbia Burque	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Moe Weiss M.D.		24a. REC'D BY REGISTRAR DATE FEB 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY JOHN T. HARRIS—HARRIS TO THE NEW YORK STATE COURTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00970

978

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keloland Memorial Hospital</u>		d. STREET ADDRESS <u>8714 36th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Holms</u> Middle <u>Martin</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30. 1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxicab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Esther Bayliss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Right Hemiplegia</u> DUE TO (c) <u>General arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>59</u> , to <u>Jan 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 16</u> , 19 <u>59</u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u>		ADDRESS (Street, city or town, state) <u>Riverdale Md 1-16 259</u>	
PHYSICIAN'S NAME (Type) <u>L W Malin</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shenandoah Mem Pk</u>	22d. LOCATION (City, town, or county) (State) <u>Winchester, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Bumphrey</u>		24. REC'D BY REGISTRAR <u>Jan 20 59</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

CERTIFICATE OF DEATH

STATE OF NEW YORK - BATHING

NAME OF DECEASED <i>James H. Henson</i>		AGE <i>62</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>April 10, 1912</i>		PLACE OF DEATH <i>Home</i>		CITY <i>New York</i>		COUNTY <i>Westchester</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		OTHER CAUSE <i>None</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Henson</i>		SIGNATURE OF DECEASED <i>James H. Henson</i>		SIGNATURE OF WITNESS <i>Dr. J. H. Henson</i>		SIGNATURE OF DECEASED <i>James H. Henson</i>	
DATE OF SIGNATURE <i>April 10, 1912</i>		DATE OF SIGNATURE <i>April 10, 1912</i>		DATE OF SIGNATURE <i>April 10, 1912</i>		DATE OF SIGNATURE <i>April 10, 1912</i>	
PLACE OF SIGNATURE <i>New York</i>		PLACE OF SIGNATURE <i>New York</i>		PLACE OF SIGNATURE <i>New York</i>		PLACE OF SIGNATURE <i>New York</i>	
CITY OF SIGNATURE <i>New York</i>		CITY OF SIGNATURE <i>New York</i>		CITY OF SIGNATURE <i>New York</i>		CITY OF SIGNATURE <i>New York</i>	
COUNTY OF SIGNATURE <i>Westchester</i>		COUNTY OF SIGNATURE <i>Westchester</i>		COUNTY OF SIGNATURE <i>Westchester</i>		COUNTY OF SIGNATURE <i>Westchester</i>	
STATE OF SIGNATURE <i>New York</i>		STATE OF SIGNATURE <i>New York</i>		STATE OF SIGNATURE <i>New York</i>		STATE OF SIGNATURE <i>New York</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00971

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Thomas Anson Sr.</u>		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-82</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Rosa J. Anson, same address as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>		24a. REC'D BY REGISTRAR <u>Jan 21 '59</u>	
ADDRESS <u>Hyattsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Calvin E. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF OHIO
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
OFFICE OF THE STATE HEALTH COMMISSIONER
COLUMBUS, OHIO

REPORT OF THE STATE HEALTH COMMISSIONER
FOR THE YEAR 1911

THE STATE HEALTH COMMISSIONER
OF THE STATE OF OHIO
REPORTS TO THE GOVERNOR
AND TO THE LEGISLATURE
FOR THE YEAR 1911

REPORT OF THE STATE HEALTH COMMISSIONER
FOR THE YEAR 1911

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REPORTS TO THE GOVERNOR
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THE STATE HEALTH COMMISSIONER
OF THE STATE OF OHIO
REPORTS TO THE GOVERNOR
AND TO THE LEGISLATURE
FOR THE YEAR 1911

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Film G238 2-13-59 et
979
CERTIFICATE OF DEATH

00972

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>23 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park 14</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Hospital</u>				d. STREET ADDRESS <u>5012 Blackfoot Pl.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Anzelone</u> Last <u>Anzelone</u>				4. DATE OF DEATH Jan. 14 19 59			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 17 -1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Hoseph Lavalli</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Rectum</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 22</u> , 19 <u>58</u> to <u>Jan. 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 14</u> , 19 <u>59</u> , and that death occurred at <u>2:27 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Rosson M.D.</u>		ADDRESS (Street, city or town, state) <u>5304 Annapolis Road</u> DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>WILLIAM D. ROSSON - M.D.</u>		<u>Bladensburg, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. SIMON & JUDE</u>		22d. LOCATION (City, town, or county) (State) <u>BLAIRSVILLE PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Murphy Thelma</u>				ADDRESS <u>Arlington, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 19 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

JAMES BOND

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00973

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ALABAMA</u> b. COUNTY <u>Geneva</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Open Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Geneva</u> 40 X 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3401-Bell St. Ave</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E</u> Last <u>ARD</u>				4. DATE OF DEATH <u>Jan 3</u> 19 <u>59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6-1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
13. FATHER'S NAME <u>William H. Gaines</u>				14. MOTHER'S MAIDEN NAME <u>Mary Blackshear</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. John T. Young</u> Address <u>Open Hill Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis/hypertension</u> DUE TO (c) <u>Chronic Nephrosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/2</u> , 19 <u>53</u> , to <u>1/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>59</u> , and that death occurred at <u>5 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Hernandez</u>				ADDRESS (Street, city or town, state) <u>2901 Fairview St. SE</u> DATE SIGNED <u>1/3/59</u>			
PHYSICIAN'S NAME (Type) <u>David R. Hernandez</u>				<u>2901 Fairview St. SE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>City</u>		22d. LOCATION (City, town, or county) (State) <u>Geneva Ala</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Sore</u> ADDRESS <u>300-4th St. E. Wash. D.C.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiser</u>	

STATISTICS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

980

CERTIFICATE OF DEATH

00974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 45 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Evelyn Bailey		4. DATE OF DEATH January 19 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 11, 1914
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) United States		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Butler		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Gettys Bailey Common law husband	
17. INFORMANT Gettys Bailey Common law husband		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage (rt. int. capsule) 1 hour 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension ?years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19 1959 , to January 19 1959 , that I last saw the deceased alive on January 19 1959 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John T. Maloney M.D.		ADDRESS (Street, city or town, state) Hyattsville, Md	
PHYSICIAN'S NAME (Type) John T. Maloney, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 1/20/59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Augusta Peyton ADDRESS 2305 Shiloh Rd. Wash, D.C.		24a. REC'D BY REGISTRAR JAN 23 59	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15, 1925

5. Time of death: 10:30 AM

6. Place of death: Home

7. Cause of death: Heart Disease

8. Signature of physician: Dr. J. Smith

9. Signature of registrar: John Doe

10. Date of registration: Jan 16, 1925

1043

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT HEIGHTS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X DISTRICT HEIGHTS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 12900 RAMBLEWOOD DRIVE	
3. NAME OF DECEASED (Type or print) First LULU Middle J. Last BALINGER		4. DATE OF DEATH Month JANUARY Day 13 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 3, 1873
9. AGE (In years, last birthday) 85		IF UNDER 1 YEAR: Months 8 Days 5 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY MS. GORT.	
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Augustus S.		14. MOTHER'S MAIDEN NAME SARAH C. Van Gompf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Virginia S. Balinger		Address 2900 Ramblewood Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive failure 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Insufficiency DUE TO (c) Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH 4 days 6-8 years 20-30 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pernicious Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 1958 to Jan 13, 1959 , that I last saw the deceased alive on Jan 12, 1959 and that death occurred at M. from the causes and on the date stated above.		ADDRESS (Street, city or town, State) 7200 Maryland Ave S.E. DATE SIGNED	
ACTUAL SIGNATURE Sidney W. Lowry		M.D. S. W. LOWRY M.D.	
PHYSICIAN'S NAME (Type) S. W. LOWRY M.D.		District Heights, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-16-1959		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) SUITLAND Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LEE FUNERAL HOME		ADDRESS 300 4th St N.E.	
24a. REC'D BY REGISTRAR JAN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM EDWARD
 1894-1964

Name of Deceased		WILLIAM EDWARD	
Date of Birth		1894	
Place of Birth		MAINE	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Farmer	
Cause of Death		Heart Disease	
Date of Death		1964	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

MAINE STATE DEPARTMENT OF HEALTH
 BANGOR, ME
 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
981
CERTIFICATE OF DEATH

00978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly c. LENGTH OF STAY IN TB 2 Days d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 22 D.C. d. STREET ADDRESS 6852 B Allentown Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fay First L. Middle Ballengee Last		4. DATE OF DEATH Jan. Month 12 Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1926
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cecil R. Gikerson		14. MOTHER'S MAIDEN NAME Eva King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-34-5328	
17. INFORMANT Harold Ballengee		18. ADDRESS 6852 B Allentown Rd. Washington, 22 D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176.1 DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma of vagina (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 11 yrs 11 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10, 1959 to Jan. 12, 1959 , that I last saw the deceased alive on Jan. 12, 1959 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 ANNAPOLIS RD. PLADDENSBURG MD. DATE SIGNED			
ACTUAL SIGNATURE William D. Rosson MD		M.D. 5304 ANNAPOLIS RD. PLADDENSBURG MD.	
PHYSICIAN'S NAME (Type) Dr. William D. Rosson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-16-59	
22c. NAME OF CEMETERY OR CREMATORY End of the Trail		22d. LOCATION (City, town, or county) (State) Clintonville, West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc 517 11th St SE		24a. REC'D BY REGISTRAR DATE JAN 16 59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Place of birth: <i>Johns Hopkins</i></p>	
<p>5. Date of death: <i>Jan 1, 1950</i></p>		<p>6. Place of death: <i>Johns Hopkins</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Signature of witness: <i>John Doe</i></p>		<p>12. Signature of witness: <i>John Doe</i></p>	
<p>13. Signature of witness: <i>John Doe</i></p>		<p>14. Signature of witness: <i>John Doe</i></p>	
<p>15. Signature of witness: <i>John Doe</i></p>		<p>16. Signature of witness: <i>John Doe</i></p>	
<p>17. Signature of witness: <i>John Doe</i></p>		<p>18. Signature of witness: <i>John Doe</i></p>	
<p>19. Signature of witness: <i>John Doe</i></p>		<p>20. Signature of witness: <i>John Doe</i></p>	
<p>21. Signature of witness: <i>John Doe</i></p>		<p>22. Signature of witness: <i>John Doe</i></p>	
<p>23. Signature of witness: <i>John Doe</i></p>		<p>24. Signature of witness: <i>John Doe</i></p>	
<p>25. Signature of witness: <i>John Doe</i></p>		<p>26. Signature of witness: <i>John Doe</i></p>	
<p>27. Signature of witness: <i>John Doe</i></p>		<p>28. Signature of witness: <i>John Doe</i></p>	
<p>29. Signature of witness: <i>John Doe</i></p>		<p>30. Signature of witness: <i>John Doe</i></p>	
<p>31. Signature of witness: <i>John Doe</i></p>		<p>32. Signature of witness: <i>John Doe</i></p>	
<p>33. Signature of witness: <i>John Doe</i></p>		<p>34. Signature of witness: <i>John Doe</i></p>	
<p>35. Signature of witness: <i>John Doe</i></p>		<p>36. Signature of witness: <i>John Doe</i></p>	
<p>37. Signature of witness: <i>John Doe</i></p>		<p>38. Signature of witness: <i>John Doe</i></p>	
<p>39. Signature of witness: <i>John Doe</i></p>		<p>40. Signature of witness: <i>John Doe</i></p>	
<p>41. Signature of witness: <i>John Doe</i></p>		<p>42. Signature of witness: <i>John Doe</i></p>	
<p>43. Signature of witness: <i>John Doe</i></p>		<p>44. Signature of witness: <i>John Doe</i></p>	
<p>45. Signature of witness: <i>John Doe</i></p>		<p>46. Signature of witness: <i>John Doe</i></p>	
<p>47. Signature of witness: <i>John Doe</i></p>		<p>48. Signature of witness: <i>John Doe</i></p>	
<p>49. Signature of witness: <i>John Doe</i></p>		<p>50. Signature of witness: <i>John Doe</i></p>	
<p>51. Signature of witness: <i>John Doe</i></p>		<p>52. Signature of witness: <i>John Doe</i></p>	
<p>53. Signature of witness: <i>John Doe</i></p>		<p>54. Signature of witness: <i>John Doe</i></p>	
<p>55. Signature of witness: <i>John Doe</i></p>		<p>56. Signature of witness: <i>John Doe</i></p>	
<p>57. Signature of witness: <i>John Doe</i></p>		<p>58. Signature of witness: <i>John Doe</i></p>	
<p>59. Signature of witness: <i>John Doe</i></p>		<p>60. Signature of witness: <i>John Doe</i></p>	
<p>61. Signature of witness: <i>John Doe</i></p>		<p>62. Signature of witness: <i>John Doe</i></p>	
<p>63. Signature of witness: <i>John Doe</i></p>		<p>64. Signature of witness: <i>John Doe</i></p>	
<p>65. Signature of witness: <i>John Doe</i></p>		<p>66. Signature of witness: <i>John Doe</i></p>	
<p>67. Signature of witness: <i>John Doe</i></p>		<p>68. Signature of witness: <i>John Doe</i></p>	
<p>69. Signature of witness: <i>John Doe</i></p>		<p>70. Signature of witness: <i>John Doe</i></p>	
<p>71. Signature of witness: <i>John Doe</i></p>		<p>72. Signature of witness: <i>John Doe</i></p>	
<p>73. Signature of witness: <i>John Doe</i></p>		<p>74. Signature of witness: <i>John Doe</i></p>	
<p>75. Signature of witness: <i>John Doe</i></p>		<p>76. Signature of witness: <i>John Doe</i></p>	
<p>77. Signature of witness: <i>John Doe</i></p>		<p>78. Signature of witness: <i>John Doe</i></p>	
<p>79. Signature of witness: <i>John Doe</i></p>		<p>80. Signature of witness: <i>John Doe</i></p>	
<p>81. Signature of witness: <i>John Doe</i></p>		<p>82. Signature of witness: <i>John Doe</i></p>	
<p>83. Signature of witness: <i>John Doe</i></p>		<p>84. Signature of witness: <i>John Doe</i></p>	
<p>85. Signature of witness: <i>John Doe</i></p>		<p>86. Signature of witness: <i>John Doe</i></p>	
<p>87. Signature of witness: <i>John Doe</i></p>		<p>88. Signature of witness: <i>John Doe</i></p>	
<p>89. Signature of witness: <i>John Doe</i></p>		<p>90. Signature of witness: <i>John Doe</i></p>	
<p>91. Signature of witness: <i>John Doe</i></p>		<p>92. Signature of witness: <i>John Doe</i></p>	
<p>93. Signature of witness: <i>John Doe</i></p>		<p>94. Signature of witness: <i>John Doe</i></p>	
<p>95. Signature of witness: <i>John Doe</i></p>		<p>96. Signature of witness: <i>John Doe</i></p>	
<p>97. Signature of witness: <i>John Doe</i></p>		<p>98. Signature of witness: <i>John Doe</i></p>	
<p>99. Signature of witness: <i>John Doe</i></p>		<p>100. Signature of witness: <i>John Doe</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00977

982 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Deland Memorial Hosp.</u>		d. STREET ADDRESS <u>18700 49th Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Wm.</u> Last <u>Beall</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gratton Beall</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ball</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Warren Nussbaum</u> Address <u>4900 Route 11, C. Heights, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Constrictive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>undetermined</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 23, 1958</u> to <u>Jan 23, 1959</u> , that I last saw the deceased alive on <u>Jan 23, 1959</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riversdale, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>L W. MALIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 26, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sherritt Smalderson</u> ADDRESS <u>313 Talbot St.</u>		24. REC'D BY REGISTRAR <u>Arthur S. Fugle</u> DATE <u>28 '59</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

383

PART I - DEATH		PART II - CAUSE OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF DEATH		8. CITY AND COUNTY	
9. STATE		10. COUNTY	
11. MARITAL STATUS		12. OCCUPATION	
13. PRESENT RESIDENCE		14. PLACE OF BIRTH	
15. DATE OF BIRTH		16. PLACE OF DEATH	
17. DATE OF DEATH		18. TIME OF DEATH	
19. PLACE OF DEATH		20. CITY AND COUNTY	
21. STATE		22. COUNTY	
23. MARITAL STATUS		24. OCCUPATION	
25. PRESENT RESIDENCE		26. PLACE OF BIRTH	
27. DATE OF BIRTH		28. PLACE OF DEATH	
29. DATE OF DEATH		30. TIME OF DEATH	
31. PLACE OF DEATH		32. CITY AND COUNTY	
33. STATE		34. COUNTY	
35. MARITAL STATUS		36. OCCUPATION	
37. PRESENT RESIDENCE		38. PLACE OF BIRTH	
39. DATE OF BIRTH		40. PLACE OF DEATH	
41. DATE OF DEATH		42. TIME OF DEATH	
43. PLACE OF DEATH		44. CITY AND COUNTY	
45. STATE		46. COUNTY	
47. MARITAL STATUS		48. OCCUPATION	
49. PRESENT RESIDENCE		50. PLACE OF BIRTH	
51. DATE OF BIRTH		52. PLACE OF DEATH	
53. DATE OF DEATH		54. TIME OF DEATH	
55. PLACE OF DEATH		56. CITY AND COUNTY	
57. STATE		58. COUNTY	
59. MARITAL STATUS		60. OCCUPATION	
61. PRESENT RESIDENCE		62. PLACE OF BIRTH	
63. DATE OF BIRTH		64. PLACE OF DEATH	
65. DATE OF DEATH		66. TIME OF DEATH	
67. PLACE OF DEATH		68. CITY AND COUNTY	
69. STATE		70. COUNTY	
71. MARITAL STATUS		72. OCCUPATION	
73. PRESENT RESIDENCE		74. PLACE OF BIRTH	
75. DATE OF BIRTH		76. PLACE OF DEATH	
77. DATE OF DEATH		78. TIME OF DEATH	
79. PLACE OF DEATH		80. CITY AND COUNTY	
81. STATE		82. COUNTY	
83. MARITAL STATUS		84. OCCUPATION	
85. PRESENT RESIDENCE		86. PLACE OF BIRTH	
87. DATE OF BIRTH		88. PLACE OF DEATH	
89. DATE OF DEATH		90. TIME OF DEATH	
91. PLACE OF DEATH		92. CITY AND COUNTY	
93. STATE		94. COUNTY	
95. MARITAL STATUS		96. OCCUPATION	
97. PRESENT RESIDENCE		98. PLACE OF BIRTH	
99. DATE OF BIRTH		100. PLACE OF DEATH	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1044 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4714 Huron Avenue</u>			e. STREET ADDRESS <u>4714 Huron Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Walter Esau Beall</u>			4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1899</u>		9. AGE (In years last birthday) <u>59</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. - Government</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia U.S. &</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. &</u>			13. FATHER'S NAME <u>Frank Beall</u>		
14. MOTHER'S MAIDEN NAME <u>unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO. <u>no</u>			17. INFORMANT <u>Mrs. Joanna Joan McClure</u> Address <u>711-31st St SE</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>January 28, 1959</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>January 28, 1959</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
22d. LOCATION (City, town or county) <u>Suitland Md</u>		22e. (State) <u>Md</u>		22f. (City or town) (County) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - D.C.</u>		ADDRESS <u>D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinta</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07078

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

[Faint, mostly illegible handwritten text and printed form fields are visible across the page. The form includes sections for patient information, medical history, and cause of death.]



1045

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges Co. - MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Woodridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Woodridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4605-24 th Ave.				d. STREET ADDRESS 14605-24 th Ave.			
3. NAME OF DECEASED (Type or print) ALAN ROLAN CHARLES BENNER				4. DATE OF DEATH JAN 9 1959			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/17/1875	
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supt. of Mail Printing Office				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Unknown Benner				14. MOTHER'S MAIDEN NAME Maggie Newton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT May Lou Benner				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X DUE TO Pyelonephritis, chronic (b) PROSTATIC HYPERTROPHY, BENIGN (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> ARTERIOSCLEROTIC HEART DISEASE; NEPHROARTERIOSCLEROSIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC 8, 1958, to JAN 9, 1959, that I last saw the deceased alive on JAN 8, 1959, and that death occurred at 3:15 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE John F. Brennan Jr.				DATE SIGNED JAN 9, 1959			
PHYSICIAN'S NAME (Type) JOHN F. BRENNAN JR.				ADDRESS (Street, city or town, state) 1034 Perry St. N.E. WASHINGTON 17, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home, Inc.				24a. REC'D BY REGISTRAR DATE JAN 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1046

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Spring</u>		c. LENGTH OF STAY in 1b <u>1 month</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Spring</u>		d. STREET ADDRESS <u>5517- Griffith Blvd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Medford Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Arthur</u> Last <u>Bergstrom</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14, 1918</u>
9. AGE (in years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR IF UNDER 2 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pilot</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>	
11. BIRTHPLACE (State or foreign country) <u>Idaho</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Bergstrom</u>		14. MOTHER'S MAIDEN NAME <u>Emma Stylin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Since 1942</u>		16. SOCIAL SECURITY NO. <u>None as #2</u>	
17. INFORMANT <u>Mrs Mary Bergstrom</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>973.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Acute Carbon monoxide poisoning</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran hose exhaust into car</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1-14</u> 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Medford Road Camp Spring, PG Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Jan 14, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN. 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Michael Funeral Home</u>		ADDRESS <u>816 4th St NW</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kirsch</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kirsch</u>	
DATE <u>JAN 19 59</u>			

100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-000

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's signature.

1. PATIENT INFORMATION

2. MEDICAL HISTORY

3. PHYSICAL EXAMINATION

4. LABORATORY TESTS

5. CAUSE OF DEATH

6. SIGNATURES

Vertical text on the right margin, likely a filing or tracking number.

983 - CERTIFICATE OF DEATH

00981

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>70 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"At her home"</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGIE</u> First <u>BERRY</u> Middle <u>BERRY</u> Last		4. DATE OF DEATH Month <u>JAN</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 3, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elementary School</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN BERRY</u>		14. MOTHER'S MAIDEN NAME <u>EMMA HEATH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>See Gilbert Laurel MD</u>	
17. INFORMANT <u>See Gilbert Laurel MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitostatic Cancer</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Breast</u> DUE TO <u>Carcinoma Bladder</u> (c) <u>Pathological fracture L4 vertebra</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>3 yrs</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pathological fracture L4 vertebra</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/17</u> , 19 <u>40</u> , to <u>1/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/1/59</u> , 19 <u>59</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Laurel MD</u>	
ACTUAL SIGNATURE <u>J. M. Warren</u> M.D.		DATE SIGNED <u>1/22/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 24/59</u>	<u>St. Phillips</u>	<u>Laurel MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgely Selby</u>		24a. REC'D BY REGISTRAR <u>JAN 26 '59</u>	
ADDRESS <u>1200 Snowden place Laurel MD</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

283

1. NAME OF DECEASED JOHN BERRY		2. SEX M	
3. AGE 35		4. DATE OF BIRTH 1893	
5. PLACE OF BIRTH MD		6. OCCUPATION LABORER	
7. CAUSE OF DEATH HEART		8. PLACE OF DEATH MD	
9. DATE OF DEATH 1928		10. TIME OF DEATH 10:00	
11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. SIGNATURE OF WITNESS J. H. Smith		14. SIGNATURE OF WITNESS J. H. Smith	
15. SIGNATURE OF WITNESS J. H. Smith		16. SIGNATURE OF WITNESS J. H. Smith	
17. SIGNATURE OF WITNESS J. H. Smith		18. SIGNATURE OF WITNESS J. H. Smith	
19. SIGNATURE OF WITNESS J. H. Smith		20. SIGNATURE OF WITNESS J. H. Smith	
21. SIGNATURE OF WITNESS J. H. Smith		22. SIGNATURE OF WITNESS J. H. Smith	
23. SIGNATURE OF WITNESS J. H. Smith		24. SIGNATURE OF WITNESS J. H. Smith	
25. SIGNATURE OF WITNESS J. H. Smith		26. SIGNATURE OF WITNESS J. H. Smith	
27. SIGNATURE OF WITNESS J. H. Smith		28. SIGNATURE OF WITNESS J. H. Smith	
29. SIGNATURE OF WITNESS J. H. Smith		30. SIGNATURE OF WITNESS J. H. Smith	
31. SIGNATURE OF WITNESS J. H. Smith		32. SIGNATURE OF WITNESS J. H. Smith	
33. SIGNATURE OF WITNESS J. H. Smith		34. SIGNATURE OF WITNESS J. H. Smith	
35. SIGNATURE OF WITNESS J. H. Smith		36. SIGNATURE OF WITNESS J. H. Smith	
37. SIGNATURE OF WITNESS J. H. Smith		38. SIGNATURE OF WITNESS J. H. Smith	
39. SIGNATURE OF WITNESS J. H. Smith		40. SIGNATURE OF WITNESS J. H. Smith	
41. SIGNATURE OF WITNESS J. H. Smith		42. SIGNATURE OF WITNESS J. H. Smith	
43. SIGNATURE OF WITNESS J. H. Smith		44. SIGNATURE OF WITNESS J. H. Smith	
45. SIGNATURE OF WITNESS J. H. Smith		46. SIGNATURE OF WITNESS J. H. Smith	
47. SIGNATURE OF WITNESS J. H. Smith		48. SIGNATURE OF WITNESS J. H. Smith	
49. SIGNATURE OF WITNESS J. H. Smith		50. SIGNATURE OF WITNESS J. H. Smith	
51. SIGNATURE OF WITNESS J. H. Smith		52. SIGNATURE OF WITNESS J. H. Smith	
53. SIGNATURE OF WITNESS J. H. Smith		54. SIGNATURE OF WITNESS J. H. Smith	
55. SIGNATURE OF WITNESS J. H. Smith		56. SIGNATURE OF WITNESS J. H. Smith	
57. SIGNATURE OF WITNESS J. H. Smith		58. SIGNATURE OF WITNESS J. H. Smith	
59. SIGNATURE OF WITNESS J. H. Smith		60. SIGNATURE OF WITNESS J. H. Smith	
61. SIGNATURE OF WITNESS J. H. Smith		62. SIGNATURE OF WITNESS J. H. Smith	
63. SIGNATURE OF WITNESS J. H. Smith		64. SIGNATURE OF WITNESS J. H. Smith	
65. SIGNATURE OF WITNESS J. H. Smith		66. SIGNATURE OF WITNESS J. H. Smith	
67. SIGNATURE OF WITNESS J. H. Smith		68. SIGNATURE OF WITNESS J. H. Smith	
69. SIGNATURE OF WITNESS J. H. Smith		70. SIGNATURE OF WITNESS J. H. Smith	
71. SIGNATURE OF WITNESS J. H. Smith		72. SIGNATURE OF WITNESS J. H. Smith	
73. SIGNATURE OF WITNESS J. H. Smith		74. SIGNATURE OF WITNESS J. H. Smith	
75. SIGNATURE OF WITNESS J. H. Smith		76. SIGNATURE OF WITNESS J. H. Smith	
77. SIGNATURE OF WITNESS J. H. Smith		78. SIGNATURE OF WITNESS J. H. Smith	
79. SIGNATURE OF WITNESS J. H. Smith		80. SIGNATURE OF WITNESS J. H. Smith	
81. SIGNATURE OF WITNESS J. H. Smith		82. SIGNATURE OF WITNESS J. H. Smith	
83. SIGNATURE OF WITNESS J. H. Smith		84. SIGNATURE OF WITNESS J. H. Smith	
85. SIGNATURE OF WITNESS J. H. Smith		86. SIGNATURE OF WITNESS J. H. Smith	
87. SIGNATURE OF WITNESS J. H. Smith		88. SIGNATURE OF WITNESS J. H. Smith	
89. SIGNATURE OF WITNESS J. H. Smith		90. SIGNATURE OF WITNESS J. H. Smith	
91. SIGNATURE OF WITNESS J. H. Smith		92. SIGNATURE OF WITNESS J. H. Smith	
93. SIGNATURE OF WITNESS J. H. Smith		94. SIGNATURE OF WITNESS J. H. Smith	
95. SIGNATURE OF WITNESS J. H. Smith		96. SIGNATURE OF WITNESS J. H. Smith	
97. SIGNATURE OF WITNESS J. H. Smith		98. SIGNATURE OF WITNESS J. H. Smith	
99. SIGNATURE OF WITNESS J. H. Smith		100. SIGNATURE OF WITNESS J. H. Smith	

1047

CERTIFICATE OF DEATH

00982

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY ARLINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) A AFB				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, ANDREWS				d. STREET ADDRESS 2713 S. WHELE STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JEAN Middle A Last BISHOP				4. DATE OF DEATH Month JAN Day 26 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 6, 1926	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William Holscher				14. MOTHER'S MAIDEN NAME Katherine W. Ashmead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 579-32-988		17. INFORMANT Address HUSBAND - Charles R. Bishop - Sec #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HODGKINS DISEASE DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 25 JAN. , 19 59 , to 26 JAN. , 19 59 , that I last saw the deceased alive on 25 JAN. , 19 59 , and that death occurred at 6:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 JAN 59 DATE SIGNED							
ACTUAL SIGNATURE Sanford L. Billet M.D.				ADDRESS USAF HOSPITAL, ANDREWS			
PHYSICIAN'S NAME (Type) SANFORD L. Billet CAPT USAF (MC)				ANDREWS A.F. Bldg. Wks 425 DC.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Colington V.A.	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Jones				ADDRESS Arlington, R.		24a. REC'D BY REGISTRAR DATE JAN 27 '59	
				24b. REGISTRAR'S SIGNATURE Christine L. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00983

984

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chenery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>1 Rt 2 Box 8A</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Melvin</u> Middle <u>Boone</u> Last		4. DATE OF DEATH <u>January</u> Month <u>5</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>30</u> <u>April</u> <u>1958</u>	
9. AGE (In years last birthday) <u>3</u> yrs <u>6</u> months <u>2</u> days		10. IF UNDER 1 YEAR <u>3</u> Months <u>2</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Samuel Boone</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Ann Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Barbara A. Boone</u> Address <u>same as 12</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-5-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle R. Rollins</u>		ADDRESS <u>4339 Hunt Pl., N.E., Wash., D.C.</u>	
24a. REC'D BY REGISTRAR <u>19</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
DATE <u>JAN 9 '59</u>			

2077152XVS

STATE OF TEXAS
COUNTY OF _____

BEFORE ME, the undersigned authority, on this _____ day of _____, 19____, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 19____.

Notary Public in and for the State of Texas
My Commission Expires _____

WITNESSES my hand and seal this _____ day of _____, 19____.

Notary Public in and for the State of Texas
My Commission Expires _____

WITNESSES my hand and seal this _____ day of _____, 19____.

Notary Public in and for the State of Texas
My Commission Expires _____

WITNESSES my hand and seal this _____ day of _____, 19____.

Notary Public in and for the State of Texas
My Commission Expires _____

WITNESSES my hand and seal this _____ day of _____, 19____.

Notary Public in and for the State of Texas
My Commission Expires _____

1 77 1 2 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 77 1 2 VS A15 (4) 15M 10/57

985

Item 7 Film G238 2-16-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00984

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
c. LENGTH OF STAY IN 1b 4 1/2 Hr.		d. STREET ADDRESS 6001 Baltimore Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert		4. DATE OF DEATH Jan. 14 1959	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 30, 1912	
9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman Washington		10b. KIND OF BUSINESS OR INDUSTRY Sanitary Division Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Claude C. Bowers		14. MOTHER'S MAIDEN NAME Edna Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO. 218240695	
17. INFORMANT Claude C Bowers		Address Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO INTESTINAL Hemorrhage DUE TO 540.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREPYLORIC GASTRIC ULCER DUE TO (c) 1 mos.		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 19 58 to JAN 14 19 59 , that I last saw the deceased alive on JAN 14 19 59 , and that death occurred at 9:22 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Perry St	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU MD RAINIER MD		DATE SIGNED 1/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/59	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	
24a. REC'D BY REGISTRAR JAN 16 '59		24b. REGISTRAR'S SIGNATURE Caring & House	

CERTIFICATE OF DEATH

882

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

PLACE OF BIRTH

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1048 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 1048 Item 7 Film G237 1-19-59 et
 CERTIFICATE OF DEATH

00985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville Md</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alms house</u>		e. STREET ADDRESS <u>Ritchie Road</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence Woodbury Brady</u>		4. DATE OF DEATH <u>Jan 12 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Stephen Brady</u>		14. MOTHER'S MAIDEN NAME <u>Mary Havner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Dora Wood</u>		Address <u>Washington D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>General Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 mo.</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostate Gland Removed Prince Georges Hospital 1952</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 1958</u> to <u>Jan 12, 1959</u> , that I last saw the deceased alive on <u>Jan 11, 1959</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C. Van Natta</u>		ADDRESS (Street, city or town, state) <u>5440 Silver Hill Rd SE</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C. VAN Natta, M.D.</u>		<u>Washington 28 W</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Collington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krand</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13, 14 Film G238 2-18-59 et

986

CERTIFICATE OF DEATH

00386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley c. LENGTH OF STAY IN 1b 11 Day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 5502 Auburn Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Brooks First Middle Lost		4. DATE OF DEATH Jan 31 19 59 Month Day Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/73 9. AGE (In years lost birthday) yrs. 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Pri. Geo. Co., Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pul. Cong + edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic Hb dis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:20 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William D. Rosson MD M.D.			
PHYSICIAN'S NAME (Type) William D. Rosson, MD 5304 Annapolis Rd., Bladensburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 2-4-59	22c. NAME OF CEMETERY OR CREMATORY Carver	22d. LOCATION (City, town, or county) (State) Murksboro Md
23. FUNERAL DIRECTOR'S SIGNATURE Nancy S Wachsmuth		ADDRESS 467 N 1st NW	24a. REC'D BY REGISTRAR DATE FEB 5 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by it, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00987

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Prince Georges General Hospital		e. STREET ADDRESS 908 64th Avenue	
3. NAME OF DECEASED (Type or print) Emma Brown		4. DATE OF DEATH January 15 19 59	
5. SEX Female	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME James Green		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Chas J, Brown; Washington, D.C.	
17. INFORMANT Chas J, Brown; Washington, D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease, with decompensation. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED January 15, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Bladensburg rd. N.E.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry L. Washington & Son		ADDRESS 467 Nat. Ave.	
24a. REC'D BY REGISTRAR DATE JAN 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HITTING DATE

NO. 100-150000

1. JUNE 1941

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

DECEASED WAS FOUND BY: [illegible] AT: [illegible]

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

988 CERTIFICATE OF DEATH

00988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. LENGTH OF STAY IN 1b adm. 8-7-56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle HOOD Last BROWN				4. DATE OF DEATH Month JANUARY Day 7 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec - 27 - 1866	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) CANADA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles A. Hood				14. MOTHER'S MAIDEN NAME JANET COWPER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. none		17. INFORMANT HOSPITAL RECORDS LAUREL SANITARIUM	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC INEFFICIENCY 422.2 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular disease DUE TO (c) many years							INTERVAL BETWEEN ONSET AND DEATH 14 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. Month 19 Day 19 Year 1959 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 8-7- , 19 56 to 1-7- , 19 59 , that I last saw the deceased alive on 1-7- , 19 59 , and that death occurred at 9:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Erika P. Kraemer M.D.				ADDRESS (Street, city or town, state) LAUREL SANITARIUM DATE SIGNED 1-7-59			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				LAUREL MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/9/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00989

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 916 64th Avenue	
3. NAME OF DECEASED (Type or print) John Francis Brown		4. DATE OF DEATH Month January Day 10 , Year 19 59	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1958
9. AGE (In years last birthday) yrs. 5		10. IF UNDER 1 YEAR Months 5 Days 3 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Savoy		14. MOTHER'S MAIDEN NAME Ellen Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. *****	
17. INFORMANT Ellen Brown; same address as # 2.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> 521X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pulmonary abscess</u> (c) <u>stating the underlying cause last.</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	
20c. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County)	
20g. (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>John J. Maloney</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 10, 1959		22a. BURIAL, CREMATION, REMOVAL (Specify)	
22b. DATE THEREOF 1-14-59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn	
22d. LOCATION (City, town, or county) Washington		22e. (State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Washington</i> ADDRESS 467 N St NE		24a. REC'D BY REGISTRAR DATE JAN 14 '59	
24b. REGISTRAR'S SIGNATURE <i>Clifton A. Hanna</i>		24c. (Signature)	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

082

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John W. Johnson		45		Male		White		Jan 15, 1920		Boston, Mass.	
Cause of Death		Disease		Organ		Nature		Site		Manner	
Myocardial Infarction		Coronary Artery Disease		Heart		Atherosclerosis		Left Ventricle		Natural	
History of Illness		Previous Illnesses		Treatment		Prognosis		Remarks		Signature of Examiner	
Patient had been ill for several days with chest pain and shortness of breath.		Hypertension, Diabetes Mellitus		Digitalis, Nitroglycerin		Poor		No autopsy performed.		J. W. Smith, M.D.	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00990

Reg. Dist. No.

990

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Willie Brown			4. DATE OF DEATH Month January Day 17 Year 1959		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 29, 1958		9. AGE (In years last birthday) yrs. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Leo Sio Brown		
14. MOTHER'S MAIDEN NAME Virginia Douglas			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Leo Brown, Eagle Harbor, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cachexia					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exposed to cold			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Aquasco	(County) P. G.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 18, 1959	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-21-59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhiney + Co. Wash, D.C.		ADDRESS 3015 12 St N.E.		24a. REC'D BY REGISTRAR 23 '59	24b. REGISTRAR'S SIGNATURE Charles E. House

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

991

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 22 Days d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights d. STREET ADDRESS 707 71st Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lucious First Bussie Middle Last		4. DATE OF DEATH Month Jan. Day 31 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		10b. KIND OF BUSINESS OR INDUSTRY Contractor	9. AGE (In years last birthday) 55 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Aiken Co. S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jeff Bussie		14. MOTHER'S MAIDEN NAME Viney Collier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lympho sarcoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Jan 9, 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 9, 1959 to Jan 31, 1959 , that I last saw the deceased alive on Jan 31, 1959 , and that death occurred at 2:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Rosson M.D.			
PHYSICIAN'S NAME (Type) William Rosson, MD 5304 Annapolis Rd., Bladensburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
2-5-59	Woodlawn	Brimmy Rd S. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ann S Washington		24a. REC'D BY REGISTRAR FEB 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1900

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

AGE

961 CERTIFICATE OF DEATH

Reg. Dist. No.

00992

1. PLACE OF DEATH o. COUNTY <u>Prince Georges Cty</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carnell Manor</u>				1. d. STREET ADDRESS <u>2021 Powhatan Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Iberesa</u> Last <u>Callow</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-1880</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Ireland</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		
13. FATHER'S NAME <u>Thomas Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Clancy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-36-0166</u>		17. INFORMANT Address <u>Robert Richard Callow 2100 N 5th NW</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>thrombosis</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis secondary</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congestive failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Washington</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>12-3-58</u> to <u>1-20-59</u> , that I last saw the deceased alive on <u>1-19-59</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Brigulio</u>				DATE SIGNED <u>20 JAN 20 1959</u>			
PHYSICIAN'S NAME (Type) <u>Arthur Brigulio</u>				<u>Wash D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawkins</u>				ADDRESS <u>1706 P. Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1048

CERTIFICATE OF DEATH

00993

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkland</u>		c. LENGTH OF STAY IN 1b <u>45 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5514 Park Land Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE</u> First Middle Lost		4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Female Caucasian</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 16, 1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Catts</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Shughure</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no.</u>	
17. INFORMANT <u>no.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure.</u> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Rheumatic Heart Disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>30 yrs.</u> <u>30 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-30</u> , 19 <u>58</u> , to <u>1-21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-21</u> , 19 <u>59</u> , and that death occurred at <u>11:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Calaneo</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3801 Suitland Rte. C.</u>	
PHYSICIAN'S NAME (Type) <u>John J. Calaneo M.D.</u>		<u>Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Olmsted Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u>		ADDRESS <u>Washington D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE N 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

CERTIFICATE OF DEATH

DATE

DECEASED

AGE

SEX

RACE

PLACE OF BIRTH

DATE

TIME

CAUSE

MANNER

EDUCATION

OCCUPATION

RELIGION

Marital Status

Usual Residence

Present Residence

Signature

Witness

Physician

Funeral Home

Interment

Remarks

Signature

Witness

Physician

Funeral Home

Interment

Remarks

Signature

Witness

Physician

Funeral Home

Interment

Remarks

Signature

Witness

Physician

Funeral Home

Interment

Remarks

Signature

Witness

Physician

Funeral Home

Interment

Remarks

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 See: Birth Cert. et

CERTIFICATE OF DEATH

Reg. Dist. No.

00994

992

1. PLACE OF DEATH o. COUNTY <i>Prince Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Prince Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>25 Riverdale Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Leland Memorial 1.4498</i>		d. STREET ADDRESS <i>14904 Riverdale, Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Baby Boy</i> First Middle Last <i>Chinn</i>		4. DATE OF DEATH Month <i>1</i> Day <i>29</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-28-59</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <i>18 mos.</i>
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Not Known</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy Rachel Chinn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address <i>Hospital Records - 4408 (Chesbury, Rd.)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia (Bronchial)</i> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>aspiration of mucus</i> (c) <i>cord tied tightly about neck at birth</i>			INTERVAL BETWEEN ONSET AND DEATH <i>16 hours</i> <i>17 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-28</i> , 19 <i>59</i> , to <i>1-29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1-29</i> , 19 <i>59</i> , and that death occurred at <i>2 p.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Louis M. Jimal</i> M.D. <i>4008 Bladensburg Rd. College Park, Md.</i>		PHYSICIAN'S NAME (Type) <i>LOUIS M. JIMAL</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/31/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis Gasch's Sons</i> ADDRESS <i>1739 Balto. Ave. Hyattsville, Md.</i>		24. REC'D BY REGISTRAR DATE <i>EB 2 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Ching S. Kwan</i>

20761712V4

CERTIFICATE OF DEATH

MAINTAIN STATE DEPT OF HEALTH - BUREAU 10

88086

Form 10-1-34

1. NAME OF DECEASED [Blank]		2. SEX [Blank]		3. RACE [Blank]		4. DATE OF BIRTH [Blank]		5. PLACE OF BIRTH [Blank]	
6. DATE OF DEATH [Blank]		7. PLACE OF DEATH [Blank]		8. CAUSE OF DEATH [Blank]		9. MANNER OF DEATH [Blank]		10. SIGNATURE OF REGISTRAR [Blank]	
11. SIGNATURE OF DECEASED [Blank]		12. SIGNATURE OF NEXT OF KIN [Blank]		13. SIGNATURE OF PHYSICIAN [Blank]		14. SIGNATURE OF MORTUARY [Blank]		15. SIGNATURE OF BURIAL [Blank]	
16. SIGNATURE OF FUNERAL HOME [Blank]		17. SIGNATURE OF CEMETERY [Blank]		18. SIGNATURE OF INTERMENT [Blank]		19. SIGNATURE OF CREMATION [Blank]		20. SIGNATURE OF OTHER [Blank]	
21. SIGNATURE OF VENDOR [Blank]		22. SIGNATURE OF OTHER [Blank]		23. SIGNATURE OF OTHER [Blank]		24. SIGNATURE OF OTHER [Blank]		25. SIGNATURE OF OTHER [Blank]	
26. SIGNATURE OF OTHER [Blank]		27. SIGNATURE OF OTHER [Blank]		28. SIGNATURE OF OTHER [Blank]		29. SIGNATURE OF OTHER [Blank]		30. SIGNATURE OF OTHER [Blank]	
31. SIGNATURE OF OTHER [Blank]		32. SIGNATURE OF OTHER [Blank]		33. SIGNATURE OF OTHER [Blank]		34. SIGNATURE OF OTHER [Blank]		35. SIGNATURE OF OTHER [Blank]	
36. SIGNATURE OF OTHER [Blank]		37. SIGNATURE OF OTHER [Blank]		38. SIGNATURE OF OTHER [Blank]		39. SIGNATURE OF OTHER [Blank]		40. SIGNATURE OF OTHER [Blank]	
41. SIGNATURE OF OTHER [Blank]		42. SIGNATURE OF OTHER [Blank]		43. SIGNATURE OF OTHER [Blank]		44. SIGNATURE OF OTHER [Blank]		45. SIGNATURE OF OTHER [Blank]	
46. SIGNATURE OF OTHER [Blank]		47. SIGNATURE OF OTHER [Blank]		48. SIGNATURE OF OTHER [Blank]		49. SIGNATURE OF OTHER [Blank]		50. SIGNATURE OF OTHER [Blank]	
51. SIGNATURE OF OTHER [Blank]		52. SIGNATURE OF OTHER [Blank]		53. SIGNATURE OF OTHER [Blank]		54. SIGNATURE OF OTHER [Blank]		55. SIGNATURE OF OTHER [Blank]	
56. SIGNATURE OF OTHER [Blank]		57. SIGNATURE OF OTHER [Blank]		58. SIGNATURE OF OTHER [Blank]		59. SIGNATURE OF OTHER [Blank]		60. SIGNATURE OF OTHER [Blank]	
61. SIGNATURE OF OTHER [Blank]		62. SIGNATURE OF OTHER [Blank]		63. SIGNATURE OF OTHER [Blank]		64. SIGNATURE OF OTHER [Blank]		65. SIGNATURE OF OTHER [Blank]	
66. SIGNATURE OF OTHER [Blank]		67. SIGNATURE OF OTHER [Blank]		68. SIGNATURE OF OTHER [Blank]		69. SIGNATURE OF OTHER [Blank]		70. SIGNATURE OF OTHER [Blank]	
71. SIGNATURE OF OTHER [Blank]		72. SIGNATURE OF OTHER [Blank]		73. SIGNATURE OF OTHER [Blank]		74. SIGNATURE OF OTHER [Blank]		75. SIGNATURE OF OTHER [Blank]	
76. SIGNATURE OF OTHER [Blank]		77. SIGNATURE OF OTHER [Blank]		78. SIGNATURE OF OTHER [Blank]		79. SIGNATURE OF OTHER [Blank]		80. SIGNATURE OF OTHER [Blank]	
81. SIGNATURE OF OTHER [Blank]		82. SIGNATURE OF OTHER [Blank]		83. SIGNATURE OF OTHER [Blank]		84. SIGNATURE OF OTHER [Blank]		85. SIGNATURE OF OTHER [Blank]	
86. SIGNATURE OF OTHER [Blank]		87. SIGNATURE OF OTHER [Blank]		88. SIGNATURE OF OTHER [Blank]		89. SIGNATURE OF OTHER [Blank]		90. SIGNATURE OF OTHER [Blank]	
91. SIGNATURE OF OTHER [Blank]		92. SIGNATURE OF OTHER [Blank]		93. SIGNATURE OF OTHER [Blank]		94. SIGNATURE OF OTHER [Blank]		95. SIGNATURE OF OTHER [Blank]	
96. SIGNATURE OF OTHER [Blank]		97. SIGNATURE OF OTHER [Blank]		98. SIGNATURE OF OTHER [Blank]		99. SIGNATURE OF OTHER [Blank]		100. SIGNATURE OF OTHER [Blank]	

962

CERTIFICATE OF DEATH

Reg. Dist. No.

00995

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b 14 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PAINT BRANCH NURSING HOME				/ d. STREET ADDRESS 11402 HOWARD ROAD			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTHA E Middle HARRIS Last Converse				4. DATE OF DEATH Month January Day 5 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/4/82	
9. AGE (In years last birthday) 76 3/4 yrs.		IF UNDER 1 YEAR Months 7 Days 15 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher (handicapped children) Own business				10b. KIND OF BUSINESS OR INDUSTRY ANTWERP, OHIO		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM HENRY HARRIS				14. MOTHER'S MAIDEN NAME JANE COTTRELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 1957 , to Jan. 5, 1959 , that I last saw the deceased alive on January 4, 1959 , and that death occurred at 2:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James M. Whitlock				ADDRESS (Street, city or town, state) 7201 Carroll Ave DATE SIGNED Jan 5, 1959			
PHYSICIAN'S NAME (Type) JAMES M. WHITLOCK				Kowa Park Road			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/5/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE JAN 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00996

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pi. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>	c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>602-62nd Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u>	4. DATE OF DEATH <u>1-12-59</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1-4-63</u>	9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Nette Colbert; same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Somnolent</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-12-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stewart</u>		24a. REC'D BY REGISTRAR <u>30-H-St., N.E.</u>	24b. REGISTRAR'S SIGNATURE <u>John T. Stewart</u>

100-1000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

003

FOR STATE
HEALTH
DEPARTMENT
BALTIMORE
16

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF MEDICAL EXAMINER: [illegible]
10. DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00998

994
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 7404 Rhode Island Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Howard L. Crisp		4. DATE OF DEATH Month Day Year January 13 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/71
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher, U. Of Md, Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A	
13. FATHER'S NAME Edward Thomas Crisp		14. MOTHER'S MAIDEN NAME Lucy Ann Brook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son, Lawrence R Crisp, College Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Thrombosis - left circumflex coronary artery (b) 2 hours DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-13, 1959, to 1-13, 1959, that I last saw the deceased alive on 1-13, 1959, and that death occurred at 4:20 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE [Signature] M.D. 4713- Berwyn Rd PHYSICIAN'S NAME (Type) Dr. Walcott L. Etienne ADDRESS (Street, city or town, state) College Park, Md DATE SIGNED 1/13/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE JAN 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN DOE</u></p>		<p>2. Date of death: <u>1945</u></p>	
<p>3. Place of death: <u>Home</u></p>		<p>4. Cause of death: <u>Heart Disease</u></p>	
<p>5. Age at death: <u>65</u></p>		<p>6. Sex: <u>Male</u></p>	
<p>7. Race: <u>White</u></p>		<p>8. Religion: <u>Protestant</u></p>	
<p>9. Marital status: <u>Married</u></p>		<p>10. Occupation: <u>Teacher</u></p>	
<p>11. Date of birth: <u>1900</u></p>		<p>12. Place of birth: <u>USA</u></p>	
<p>13. Name of informant: <u>John Doe</u></p>		<p>14. Signature of informant: <u>[Signature]</u></p>	
<p>15. Name of registrar: <u>John Doe</u></p>		<p>16. Signature of registrar: <u>[Signature]</u></p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1051

CERTIFICATE OF DEATH

00999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HEIGHTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HEIGHTS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>344 CREE DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>COURTNEY B. CROWDER</u>				4. DATE OF DEATH Month Day Year <u>Jan. 13 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 6, 1870</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM HENRY BATTE</u>				14. MOTHER'S MAIDEN NAME <u>SALLY BAILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>H. Rotelle Wingfield</u> Address <u>344 Cree Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1.5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1.11.59</u> , 19 <u>59</u> , to <u>1.13.59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1.12.59</u> , and that death occurred at <u>5:00 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank S. Pellegrini</u> M.D.				ADDRESS (Street, city or town, state) <u>3409 Ala Ave SE</u>		DATE SIGNED <u>Jan 13 1959</u>	
PHYSICIAN'S NAME (Type) <u>FRANK S. PELLEGRINI</u>				<u>Wash 20 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HIGH HILLS</u>		22d. LOCATION (City, town, or county) (State) <u>JARRATT, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoma</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01000

Reg. Dist. No.

1052

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Knoll		c. LENGTH OF STAY IN 1b 2½ years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Knoll	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4734 East Avenue			d. STREET ADDRESS 4734 East Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Irene Petersen Davis			4. DATE OF DEATH Month January Day 20 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1908		9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Rhode Island	
13. FATHER'S NAME Emil Nichol Petersen			14. MOTHER'S MAIDEN NAME Viola Thompson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address John Malcolm Davis, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (b) Due to compression of upper respiratory tract (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs and lodged between stairs and door at bottom			
20c. TIME OF INJURY Month, Day, Year 6:00 p.m. 1/20/ 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Oak Knoll Prince Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James I. Boyd</i> EXAMINER'S NAME (Type) James I. Boyd			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 21, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>		ADDRESS 4th & Mass Ave Washington		24a. REC'D BY REGISTRAR JAN 23 '59	
				24b. REGISTRAR'S SIGNATURE <i>Colburn & Thomas</i>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MENTAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Johnnie Brown		Male		35		Jan 15, 1922	
Place of Birth		Race		Religion		Marital Status	
New York City		Caucasian		Roman Catholic		Single	
Occupation		Cause of Death		Manner of Death		Place of Death	
Laborer		Heart Disease		Natural		Home	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Date of Death		Date of Burial		Date of Interment	
Jan 10, 1922		Jan 15, 1922		Jan 18, 1922		Jan 20, 1922	

995

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 12 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 411 Addison Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Effie A Dunnington				4. DATE OF DEATH Month Day Year Jan. 26 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1914	
9. AGE (In years last birthday) yrs. 44		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S. A.							
13. FATHER'S NAME Alfonso Ordey				14. MOTHER'S MAIDEN NAME Gertude Fowler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Walter Dunnington, Husband		Address Same as Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 561.4 DUE TO Intest. obstruct. (uncancerous tumor) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intest. obstruct. (uncancerous tumor) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma matr. sec. to Adeno ca. breast							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 29, 1958 , to Jan. 26, 1959 , that I last saw the deceased alive on Jan 26, 1959 , and that death occurred at 12:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7016 - Gray St., Seat Pleasant, Md. DATE SIGNED W. W. Chambers							
ACTUAL SIGNATURE Max M. Herzberg M.D. 7016 - Gray St., Seat Pleasant, Md.							
PHYSICIAN'S NAME (Type) Dr. Max Herzberg							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial		22b. DATE THEREOF 1/29/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town or county) (State) Seat Pleasant Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Cordac Wash. D.C.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE JAN 29 '59	
				24b. REGISTRAR'S SIGNATURE Walter Dunnington			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7122

963

CERTIFICATE OF DEATH

01002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY WASHINGTON, D. C. 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b NOV. 1957			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR				d. STREET ADDRESS 1726 M STREET, N. W.			
3. NAME OF DECEASED (Type or print) First MARY Middle CECELIA Last EGGLESTON				4. DATE OF DEATH Month JANUARY Day 17 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 21, 1869	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MONTG. CO., MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME XX CHARLES A. EGGLESTON				14. MOTHER'S MAIDEN NAME XX MARTHA BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Msgr. Joseph T. Kennedy, Forest Glen, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Heart Failure DUE TO Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c) Sudden							INTERVAL BETWEEN ONSET AND DEATH 2 days 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 , 19____, to 1/17/59 , 19____, that I last saw the deceased alive on 1/17/59 , 19____, and that death occurred at 12:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William P. Argy				DATE SIGNED 1/17/59			
PHYSICIAN'S NAME (Type) William P. Argy				M.D. 11500			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/20/59		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) FOREST GLEN, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 21 '59	
				24b. REGISTRAR'S SIGNATURE William E. Kennedy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

996

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1 C Garden Way			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
c. LENGTH OF STAY IN 1b 55 days				d. STREET ADDRESS Greenbelt			
3. NAME OF DECEASED (Type or print) First Helen Middle Ewing Last Evans				4. DATE OF DEATH Month January Day 15 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/26/96	
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME William Corwin				14. MOTHER'S MAIDEN NAME Florence Garrett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Tim Evans Son Address Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180x DUE TO Cremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Renal failure DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 month 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension left kidney				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 15 , 19 50 , to Jan. 15 , 19 59 , that I last saw the deceased alive on January 15 , 19 59 , and that death occurred at 7:58 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Helen Wodak				DATE SIGNED 30-C RIDGE RD, GREENBELT, Md. 1-16-59			
PHYSICIAN'S NAME (Type) HANS WODAK				30-C Ridge Rd., Greenbelt, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/20/59		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM.		22d. LOCATION (City, town, or county) (State) ADA, OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE For. Dawlin's Sons ADDRESS 4444 D.C.				24a. REC'D BY REGISTRAR JAN 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 HYATTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9302 ADELPHIA ROAD</u>				d. STREET ADDRESS <u>1 (# 9302 ADELPHIA ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANTHONY</u> Middle <u>F.</u> Last <u>FEDERICI</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-93</u>		9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATING ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN FEDERICI</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE VENTURI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>577-07-1364</u>		17. INFORMANT Address <u>Wash. D. C.</u> <u>Mrs. Rose Kuttner 5415 Conn. Ave. N. W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO <u>Hypertensive arteriosclerotic Heart Disease</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, 40yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>5 years - Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>52</u> , to <u>Jan 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 30</u> , 19 <u>58</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D. <u>8237 Georgia Ave Silver Spring Md 1/3-59</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM 8237 GEORGIA AVE. SILVER SPRING, MARYLAND.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>Wash. D. C.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>FRANCIS J. COLLINS 3821 14TH. ST. N.W.</u>				<u>Jan 8 '59</u>		<u>Colleen S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

997

1. PLACE OF DEATH a. COUNTY Prince George				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 31 D^{ys}				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince George				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden				d. STREET ADDRESS McClaine Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Rebecca L. Ferguson				4. DATE OF DEATH Month Day Year January 8 1959				5. SEX Female				6. COLOR OR RACE Colored				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH July 7 1916				9. AGE (In years last birthday) 42				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S. A				13. FATHER'S NAME William Harrison				14. MOTHER'S MAIDEN NAME Anna Hamilton				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Husband Ernest Ferguson				Address Glen Arden McClaine Ave. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Uremia DUE TO (b) C.V.A. DUE TO (c) Intestinal Obstruction Probably due to cancer of colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from Jan 1 , 19 59 , to Jan 8 , 19 59 , that I last saw the deceased alive on Jan 7 , 19 59 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED																																							
ACTUAL SIGNATURE Wm. A. Holbrook (M.D.)																PHYSICIAN'S NAME (Type) Dr. William A Holbrook Jr.																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial																22b. DATE THEREOF Jan. 12 59								22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery								22d. LOCATION (City, town, or county) (State) Washington, D.C.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire																ADDRESS 1820 9th St., N.W. Washington 1, D.C.								24a. REC'D BY REGISTRAR DATE JAN 12 59								24b. REGISTRAR'S SIGNATURE Arthur L. Kline							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1053

CERTIFICATE OF DEATH

01006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights (Md.)</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sutland Nursing Home</u>			d. STREET ADDRESS <u>2709 Colebrook Drive</u>		
3. NAME OF DECEASED (Type or print) <u>Herman Payson Gould</u>			4. DATE OF DEATH <u>January 25, 1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 Apr 1883</u>		9. AGE (In years last birthday) <u>75</u> yrs. <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Optometrist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(Retired)</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Isaac Gould</u>			14. MOTHER'S MAIDEN NAME <u>Celia — — —</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1901 - 1904</u>		16. SOCIAL SECURITY NO. <u>578-42-533</u>		17. INFORMANT <u>Harold E. Gould</u> Address <u>2709 Colebrook Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis-Generdized</u> (c) <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis - 3 days</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>January 16, 1959</u> , to <u>January 25, 1959</u> , that I last saw the deceased alive on <u>January 25, 1959</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Walcutt W. Gibson</u> M.D.			DATE SIGNED <u>2412 Minnesota Ave. S.E.</u>		
PHYSICIAN'S NAME (Type) <u>Walcutt W. Gibson</u>			<u>Washington 20, D.C.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Jan-28-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	
22d. LOCATION (City, town, or county) <u>Arlington</u>		(State) <u>Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargansky & Sons</u> ADDRESS <u>3501-14 St. N.W.</u>			24a. RECEIVED BY REGISTRAR <u>Jan 25 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01007

1054

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside				c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews, AAFB, 25, D.C.				d. STREET ADDRESS 7616 Atwood St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SUSAN LORRAINE GRISWOLD				4. DATE OF DEATH Month Day Year Jan 4 19 59			
5. SEX Fem		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Sep 58	
9. AGE (In years last birthday) yrs. 3		10. AGE (In years last birthday) yrs. 26		11. BIRTHPLACE (State or foreign country) Maryland D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA				10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Maryland D.C.	
13. FATHER'S NAME Richard Edward Griswold				14. MOTHER'S MAIDEN NAME Judith Barrett Newton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NA		16. SOCIAL SECURITY NO. NA		17. INFORMANT Address Father-Richard E Griswold-Same as item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Jan , 19 59 , to 4 Jan , 19 59 , that I last saw the deceased alive on 4 Jan , 19 59 , and that death occurred at 1153 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS DATE SIGNED 4 Jan 59							
ACTUAL SIGNATURE Douglas F. Pierce M.D.				PHYSICIAN'S NAME (Type) DOUGLAS F. PIERCE, CAPT, USAF(MC) Andrews Air Force Base, Wash 25, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 7, 1959		22c. NAME OF CEMETERY OR CREMATORY PORTSMOUTH VA.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME ADDRESS 816 H ST. N.E. WASH. DC.				24a. REC'D BY REGISTRAR JAN 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1055 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01008

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN lb 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2501- Harcross Street			d. STREET ADDRESS 2501- Harcross St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ludwig Heward Hammer			4. DATE OF DEATH Month Day Year Jan 3 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1911		9. AGE (Years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S. &			13. FATHER'S NAME Alfred I Hammer		
14. MOTHER'S MAIDEN NAME Sadie Foster			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or dates of service) In service Korea		
16. SOCIAL SECURITY NO. 228-05-6441			17. INFORMANT Mrs Mary Elizabeth Hammer, Pomeroy St		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gun shot wound of head (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with pistol			
20c. TIME OF INJURY Month, Day, Year 1-3 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Hillcrest Heights		20g. (County) Prince Georges		20h. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (specify) BURIAL		22b. DATE THEREOF JAN. 7, 1959		22c. NAME OF CEMETERY OR CREMATORY CULPEPPER VA.	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME		ADDRESS 816 H St. N.E., Wash DC		24a. REC'D BY REGISTRAR DATE JAN 6 '59	
				24b. REGISTRAR'S SIGNATURE Anthony S. Thomas	

998
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>23hrs. 45 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>9514 Rhode Island Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Walter R. Harr</u>		4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-79</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired U S Govt Naval Ordnance</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Oliver Harr</u>		14. MOTHER'S MAIDEN NAME <u>Mary R Browning</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary E Wife</u>		Address <u>Address Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor. occlus. left car artery</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocard. infarct.</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>59</u> , to <u>1/16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>January 16</u> , 19 <u>59</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>College Park, Md.</u> DATE SIGNED <u>1/16-59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Etienne</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beltsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE, MD

DATE OF DEATH

PLACE OF DEATH

DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

999

CERTIFICATE OF DEATH

Reg. Dist. No.

01010

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 22 Minutes d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS Rtl Box 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Hawkins		4. DATE OF DEATH Month Jan Day 19 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 19 59
9. AGE (In years lost birthday) yrs. 22		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Charles S. Hawkins		14. MOTHER'S MAIDEN NAME Alice Marie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Charles Hawkins	
17. INFORMANT Charles Hawkins		Address: Brandywine, Md	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra uterine death cause unknown 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 773.0 DUE TO (c) 773.0		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-19-59 , 19 59 , to 1-19 , 19 59 , that I last saw the deceased alive on 1-19-59 , 19 59 , and that death occurred at 7:42 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St. Hyattsville, Md	
PHYSICIAN'S NAME (Type) John Perkins		DATE SIGNED Jan 19 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md		24a. REC'D BY REGISTRAR Jan 26 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

CERTIFICATE OF DEATH

382

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
CITY		COUNTY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF WITNESS		SIGNATURE OF CORONER	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
SIGNATURE OF MINISTER		SIGNATURE OF CHURCH	
SIGNATURE OF BURIAL		SIGNATURE OF CEMETERY	
SIGNATURE OF FUNERAL HOME		SIGNATURE OF STATE DEPARTMENT OF HEALTH	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01011

Reg. Dist. No.

1000

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Rt. Box 3.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alice Marie Hawkins				4. DATE OF DEATH Month Day Year January 19, 1959			
5. SEX Female		6. COLOR OR RACE col..		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-5-33	
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Archie Smith				14. MOTHER'S MAIDEN NAME Sadie Oakes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO.		17. INFORMANT Charles Hawkins; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Therapeutic procedure DUE TO 660x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Caudal anesthesia for childbirth DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 954x							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) caudal anesthesia. Death occurred a short time after the completion of/					
20c. TIME OF INJURY Month, Day, Year 6.30 p.m. 1-19- 1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Cheverly Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 30, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-59		22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE JAN 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. For burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01012

1001

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fletchertown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Charles Henson		4. DATE OF DEATH Month January Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-30-04
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Arthur Smith	
14. MOTHER'S MAIDEN NAME Georgianna Henson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Henrietta Johnson; same address as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) Coronary sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City of town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED January 20, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-27-59	22c. NAME OF CEMETERY OR CREMATORY Fork A.M.E. Zion Church	22d. LOCATION (City, town, or county) (State) Ann Arundel County, Md
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. Funeral Home - 3015 12th St., N.E.		24a. REC'D BY REGISTRAR JAN 23 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Book of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Index Number

County

Residence

Age

Occupation

Married

Single

Widow

First Death

Second Death

Time of Death

Place of Death

Medical History

Present Condition

General Remarks

Signature of Medical Examiner

January 20, 1933

Death Certificate

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1056 CERTIFICATE OF DEATH

01013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ardmore Md		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ardmore Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ardmore Road				d. STREET ADDRESS Ardmore Road Box 387			
3. NAME OF DECEASED (Type or print) First Robert Clinton Middle Herrmann Last				4. DATE OF DEATH Month January Day 13 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Nov 5, 1893		9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police		10b. KIND OF BUSINESS OR INDUSTRY U S Steel Co		11. BIRTHPLACE (State or foreign country) Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME William F Herrmann			
14. MOTHER'S MAIDEN NAME Katherine Shirly				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. W W 1		17. INFORMANT Address Helen Herrmann Ardmore Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from March, 1953 , to 1/13, 1959 , that I last saw the deceased alive on 12/14, 1958 , and that death occurred on 12/13/59 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i> M.D. 441079th Ave				ADDRESS (Street, city or town, state) DATE SIGNED 1/13/59			
PHYSICIAN'S NAME (Type) F. E. Mouser, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National			
22d. LOCATION (City, town, or county) (State) Arlington Virginia		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gasch's Sons Hyattsville Md.					
24a. REC'D BY REGISTRAR DATE JAN 16 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kane</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

974

CERTIFICATE OF DEATH

01014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. RAINIER</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 MT. RAINIER</u>	
		d. STREET ADDRESS <u>3722 -35 ST</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ILDA</u> First <u>BOWEN</u> Middle <u>HEYL</u> Last		4. DATE OF DEATH <u>JAN</u> Month <u>29</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 28 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAGAZINE</u>	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN BOWEN</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE WEISENBURGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-200910</u>	
17. INFORMANT <u>Nell L. Bowen</u> Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8</u> <u>INTESTINAL OBSTRUCTION</u> DUE TO (b) <u>METASTATIC CARCINOMA</u> DUE TO (c) <u>CARCINOMA COLON</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 MOS</u> <u>6 MOS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG</u> , 19 <u>58</u> , to <u>JAN</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JAN 28</u> , 19 <u>59</u> , and that death occurred at <u>5 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin S. Miller</u>		ADDRESS (Street, city or town, state) <u>3824-34 ST Mt Rainier</u> DATE SIGNED <u>Jan 29 1959</u>	
PHYSICIAN'S NAME (Type) <u>BENJAMIN S. MILLER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/31/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalley's Funeral Home</u> ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 3 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1057

CERTIFICATE OF DEATH

00844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Bel/A Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Faulkner	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ARTHUR HINDLE		4. DATE OF DEATH Month Day Year January 31 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hindle		14. MOTHER'S MAIDEN NAME Emma Greer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mr. Earl Hindle (Son)		Address Bel Alton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden Cardiac Death and Disease (c) Aging Process PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-23, 1959, to 1-31, 1959, that I last saw the deceased alive on 1-30, 1959, and that death occurred at 4:48 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Richard H. Dobson M.D.		Richard H. Dobson	
PHYSICIAN'S NAME (Type) Richard H. Dobson		Richard H. Dobson	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/1959	
22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		22d. LOCATION (City, town, or county) (State) Hill Top, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard H. Dobson		24a. REC'D BY REGISTRAR FEB 9 '59	
AREHART FUNERAL HOME, INC. * LA PLATA, MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01015

CERTIFICATE OF DEATH

1002

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Prince George</i> MARYLAND		STATE <i>Md</i> COUNTY <i>Pr Geo.</i>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Laurel</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	
TOWN <i>Laurel</i>		LENGTH OF STAY (in this place) <i>46 yrs 41</i>		TOWN <i>Laurel</i>		STREET ADDRESS (If rural give location) <i>1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Mattie V. Hopkins</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>January 29 19 59</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Nov 18 1891</i>	9. AGE last birthday <i>67</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John F. Milbrook</i>				14. MOTHER'S MAIDEN NAME <i>Nancy Lett</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT'S ADDRESS <i>T. Bailey Hopkins, Laurel, Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199.2 IMMEDIATE CAUSE (A) <i>Pulmonary Embolism</i>						INTERVAL BETWEEN ONSET AND DEATH <i>11 hr</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Carcinoma Liver Spleen + Intestine</i>						<i>1 yr</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>—</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>—</i>							
19a. DATE OF OPERATION <i>Sept 28</i>		19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of Intestine Spleen + Liver</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <i>—</i>		21e. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> <i>—</i>		21f. HOW DID INJURY OCCUR? <i>—</i>			
22. I hereby certify that I attended the deceased from <i>Sept 1</i> , 19 <i>58</i> , to <i>Jan 29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Jan 28</i> , 19 <i>59</i> , and that death occurred at <i>9 A</i> .M, from the causes and on the date stated above.							
SIGNATURE <i>D. B. Bernard</i>		M.D. <i>314 Compton Ave Laurel, Md</i>		ADDRESS (Street, city, town, state)		DATE SIGNED <i>1/31/59</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Feb 1 1959</i>		NAME OF CEMETERY OR CREMATORY <i>Long Hill Cem.</i>		LOCATION (City, town, or county) (State) <i>Laurel, Md</i>	
24. REC'D BY REGISTRAR <i>FEB 3 '59</i>		REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Donaldson</i>		ADDRESS <i>Laurel, Md</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01016

1058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 435 Valley Avenue, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles - Ives		4. DATE OF DEATH Month 1 Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR: Months - Days - Hours - Min -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger		10b. KIND OF BUSINESS OR INDUSTRY Canadian Embassy	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Israel Ives		14. MOTHER'S MAIDEN NAME Clara Bolzack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X PULMONARY HEMORRHAGE DUE TO (b) PULMONARY TUBERCULOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO TUBERCULOUS ADENITIS & SINUS RT. NECK PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TUBERCULOUS PLEURISY, RT; LOCALIZED PNEUMOTHORAX, LEFT			INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 4 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/9/1959, to 1/14/1959, that I last saw the deceased alive on 1/13/1959, and that death occurred at 7:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 1/14/59	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1/17/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE B. G. Mattingly		24a. REC'D BY REGISTRAR 1.31-1/26/59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEST VIRGINIA OF DEATH

WEST VIRGINIA
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS

Name of Deceased		Date of Death	
Sex		Age	
Place of Birth		Cause of Death	
Occupation		Manner of Death	
Residence		Burial Place	
Signature of Registrar		Signature of Physician	
Date of Registration		Time of Registration	
County		City	
State		District	

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Prince Georges

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Dist. of Col. b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

D.O.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hosp.

d. STREET ADDRESS

636 L. Street, N.W.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

First William

Middle

Last James

4. DATE OF DEATH

Month

Day

Year

January

12,

19 59

5. SEX

Male

6. COLOR OR RACE

colored

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

?

9. AGE (In years last birthday)

60?

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Warehouse man

10b. KIND OF BUSINESS OR INDUSTRY

Moving

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF WHAT COUNTRY?

?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

578-12-9314

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

434.1

DUE TO

Acute congestive heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.

19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

John J. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

January 12, 1959

EXAMINER'S NAME (Type)

John T. Maloney, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

1/21/59

22c. NAME OF CEMETERY OR CREMATORY

Woodlawn

22d. LOCATION (City, town, or county)

Washington

(State)

D.C.

23. FUNERAL DIRECTOR'S SIGNATURE

Hoffman

ADDRESS

909-6 St. N.W.

24a. REC'D BY REGISTRAR

DATE JAN 22 '59

24b. REGISTRAR'S SIGNATURE

C. S. K. K.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARLAND & THE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH: 10/10/1917

NAME OF DECEASED: JOHN J. MARLAND

RESIDENCE: 1000 10th Ave. New York City

CAUSE OF DEATH: Myocardial Infarction

DATE OF EXAMINATION: 10/10/1917

PLACE OF EXAMINATION: 1000 10th Ave. New York City

AGE: 45

SEX: Male

DATE OF BIRTH: 10/10/1872

DATE OF DEATH: 10/10/1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G238 2-9-59 et

01018

965

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D. C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Manor Nursing Home</i>		e. STREET ADDRESS <i>3043 "P" St., N. W.</i>	
3. NAME OF DECEASED (Type or print) First <i>Delia</i> Middle <i>Jesner</i> Last <i>Jesner</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>24</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 10 1874</i>
9. AGE (In years last birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>14</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Lesieur</i>		14. MOTHER'S MAIDEN NAME <i>Philomene Lamere</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Louis Lesieur</i>		Address <i>737 N. Nelson Arlington, Va</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Pulmonary</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio Sclerosis</i> DUE TO (c) <i>Cerebral Arterio Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/27</i> , 19 <i>58</i> , to <i>1/24</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1/23</i> , 19 <i>59</i> , and that death occurred at <i>12:45</i> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3066 - Quince - N. W.</i> DATE SIGNED <i>Jan 27 '59</i>			
ACTUAL SIGNATURE <i>Robert L. Ladden</i> M.D.			
PHYSICIAN'S NAME (Type) <i>ESTON L. YOUNG</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>1/24/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Ignace Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Mascha Sore</i>		24a. REC'D BY REGISTRAR <i>Jan 27 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form No. 100

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>		<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>		<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF REGISTRAR</p>		<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. NAME OF DECEASED</p>		<p>14. SEX</p>		<p>15. AGE</p>		<p>16. DATE OF BIRTH</p>		<p>17. PLACE OF BIRTH</p>		<p>18. DATE OF DEATH</p>		<p>19. PLACE OF DEATH</p>		<p>20. CAUSE OF DEATH</p>		<p>21. MANNER OF DEATH</p>		<p>22. SIGNATURE OF REGISTRAR</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF WITNESSES</p>	
<p>25. NAME OF DECEASED</p>		<p>26. SEX</p>		<p>27. AGE</p>		<p>28. DATE OF BIRTH</p>		<p>29. PLACE OF BIRTH</p>		<p>30. DATE OF DEATH</p>		<p>31. PLACE OF DEATH</p>		<p>32. CAUSE OF DEATH</p>		<p>33. MANNER OF DEATH</p>		<p>34. SIGNATURE OF REGISTRAR</p>		<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF WITNESSES</p>	
<p>37. NAME OF DECEASED</p>		<p>38. SEX</p>		<p>39. AGE</p>		<p>40. DATE OF BIRTH</p>		<p>41. PLACE OF BIRTH</p>		<p>42. DATE OF DEATH</p>		<p>43. PLACE OF DEATH</p>		<p>44. CAUSE OF DEATH</p>		<p>45. MANNER OF DEATH</p>		<p>46. SIGNATURE OF REGISTRAR</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF WITNESSES</p>	
<p>49. NAME OF DECEASED</p>		<p>50. SEX</p>		<p>51. AGE</p>		<p>52. DATE OF BIRTH</p>		<p>53. PLACE OF BIRTH</p>		<p>54. DATE OF DEATH</p>		<p>55. PLACE OF DEATH</p>		<p>56. CAUSE OF DEATH</p>		<p>57. MANNER OF DEATH</p>		<p>58. SIGNATURE OF REGISTRAR</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF WITNESSES</p>	
<p>61. NAME OF DECEASED</p>		<p>62. SEX</p>		<p>63. AGE</p>		<p>64. DATE OF BIRTH</p>		<p>65. PLACE OF BIRTH</p>		<p>66. DATE OF DEATH</p>		<p>67. PLACE OF DEATH</p>		<p>68. CAUSE OF DEATH</p>		<p>69. MANNER OF DEATH</p>		<p>70. SIGNATURE OF REGISTRAR</p>		<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF WITNESSES</p>	
<p>73. NAME OF DECEASED</p>		<p>74. SEX</p>		<p>75. AGE</p>		<p>76. DATE OF BIRTH</p>		<p>77. PLACE OF BIRTH</p>		<p>78. DATE OF DEATH</p>		<p>79. PLACE OF DEATH</p>		<p>80. CAUSE OF DEATH</p>		<p>81. MANNER OF DEATH</p>		<p>82. SIGNATURE OF REGISTRAR</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF WITNESSES</p>	
<p>85. NAME OF DECEASED</p>		<p>86. SEX</p>		<p>87. AGE</p>		<p>88. DATE OF BIRTH</p>		<p>89. PLACE OF BIRTH</p>		<p>90. DATE OF DEATH</p>		<p>91. PLACE OF DEATH</p>		<p>92. CAUSE OF DEATH</p>		<p>93. MANNER OF DEATH</p>		<p>94. SIGNATURE OF REGISTRAR</p>		<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF WITNESSES</p>	
<p>97. NAME OF DECEASED</p>		<p>98. SEX</p>		<p>99. AGE</p>		<p>100. DATE OF BIRTH</p>		<p>101. PLACE OF BIRTH</p>		<p>102. DATE OF DEATH</p>		<p>103. PLACE OF DEATH</p>		<p>104. CAUSE OF DEATH</p>		<p>105. MANNER OF DEATH</p>		<p>106. SIGNATURE OF REGISTRAR</p>		<p>107. SIGNATURE OF DECEASED</p>		<p>108. SIGNATURE OF WITNESSES</p>	
<p>109. NAME OF DECEASED</p>		<p>110. SEX</p>		<p>111. AGE</p>		<p>112. DATE OF BIRTH</p>		<p>113. PLACE OF BIRTH</p>		<p>114. DATE OF DEATH</p>		<p>115. PLACE OF DEATH</p>		<p>116. CAUSE OF DEATH</p>		<p>117. MANNER OF DEATH</p>		<p>118. SIGNATURE OF REGISTRAR</p>		<p>119. SIGNATURE OF DECEASED</p>		<p>120. SIGNATURE OF WITNESSES</p>	
<p>121. NAME OF DECEASED</p>		<p>122. SEX</p>		<p>123. AGE</p>		<p>124. DATE OF BIRTH</p>		<p>125. PLACE OF BIRTH</p>		<p>126. DATE OF DEATH</p>		<p>127. PLACE OF DEATH</p>		<p>128. CAUSE OF DEATH</p>		<p>129. MANNER OF DEATH</p>		<p>130. SIGNATURE OF REGISTRAR</p>		<p>131. SIGNATURE OF DECEASED</p>		<p>132. SIGNATURE OF WITNESSES</p>	
<p>133. NAME OF DECEASED</p>		<p>134. SEX</p>		<p>135. AGE</p>		<p>136. DATE OF BIRTH</p>		<p>137. PLACE OF BIRTH</p>		<p>138. DATE OF DEATH</p>		<p>139. PLACE OF DEATH</p>		<p>140. CAUSE OF DEATH</p>		<p>141. MANNER OF DEATH</p>		<p>142. SIGNATURE OF REGISTRAR</p>		<p>143. SIGNATURE OF DECEASED</p>		<p>144. SIGNATURE OF WITNESSES</p>	
<p>145. NAME OF DECEASED</p>		<p>146. SEX</p>		<p>147. AGE</p>		<p>148. DATE OF BIRTH</p>		<p>149. PLACE OF BIRTH</p>		<p>150. DATE OF DEATH</p>		<p>151. PLACE OF DEATH</p>		<p>152. CAUSE OF DEATH</p>		<p>153. MANNER OF DEATH</p>		<p>154. SIGNATURE OF REGISTRAR</p>		<p>155. SIGNATURE OF DECEASED</p>		<p>156. SIGNATURE OF WITNESSES</p>	
<p>157. NAME OF DECEASED</p>		<p>158. SEX</p>		<p>159. AGE</p>		<p>160. DATE OF BIRTH</p>		<p>161. PLACE OF BIRTH</p>		<p>162. DATE OF DEATH</p>		<p>163. PLACE OF DEATH</p>		<p>164. CAUSE OF DEATH</p>		<p>165. MANNER OF DEATH</p>		<p>166. SIGNATURE OF REGISTRAR</p>		<p>167. SIGNATURE OF DECEASED</p>		<p>168. SIGNATURE OF WITNESSES</p>	
<p>169. NAME OF DECEASED</p>		<p>170. SEX</p>		<p>171. AGE</p>		<p>172. DATE OF BIRTH</p>		<p>173. PLACE OF BIRTH</p>		<p>174. DATE OF DEATH</p>		<p>175. PLACE OF DEATH</p>		<p>176. CAUSE OF DEATH</p>		<p>177. MANNER OF DEATH</p>		<p>178. SIGNATURE OF REGISTRAR</p>		<p>179. SIGNATURE OF DECEASED</p>		<p>180. SIGNATURE OF WITNESSES</p>	
<p>181. NAME OF DECEASED</p>		<p>182. SEX</p>		<p>183. AGE</p>		<p>184. DATE OF BIRTH</p>		<p>185. PLACE OF BIRTH</p>		<p>186. DATE OF DEATH</p>		<p>187. PLACE OF DEATH</p>		<p>188. CAUSE OF DEATH</p>		<p>189. MANNER OF DEATH</p>		<p>190. SIGNATURE OF REGISTRAR</p>		<p>191. SIGNATURE OF DECEASED</p>		<p>192. SIGNATURE OF WITNESSES</p>	
<p>193. NAME OF DECEASED</p>		<p>194. SEX</p>		<p>195. AGE</p>		<p>196. DATE OF BIRTH</p>		<p>197. PLACE OF BIRTH</p>		<p>198. DATE OF DEATH</p>		<p>199. PLACE OF DEATH</p>		<p>200. CAUSE OF DEATH</p>		<p>201. MANNER OF DEATH</p>		<p>202. SIGNATURE OF REGISTRAR</p>		<p>203. SIGNATURE OF DECEASED</p>		<p>204. SIGNATURE OF WITNESSES</p>	
<p>205. NAME OF DECEASED</p>		<p>206. SEX</p>		<p>207. AGE</p>		<p>208. DATE OF BIRTH</p>		<p>209. PLACE OF BIRTH</p>		<p>210. DATE OF DEATH</p>		<p>211. PLACE OF DEATH</p>		<p>212. CAUSE OF DEATH</p>		<p>213. MANNER OF DEATH</p>		<p>214. SIGNATURE OF REGISTRAR</p>		<p>215. SIGNATURE OF DECEASED</p>		<p>216. SIGNATURE OF WITNESSES</p>	
<p>217. NAME OF DECEASED</p>		<p>218. SEX</p>		<p>219. AGE</p>		<p>220. DATE OF BIRTH</p>		<p>221. PLACE OF BIRTH</p>		<p>222. DATE OF DEATH</p>		<p>223. PLACE OF DEATH</p>		<p>224. CAUSE OF DEATH</p>		<p>225. MANNER OF DEATH</p>		<p>226. SIGNATURE OF REGISTRAR</p>		<p>227. SIGNATURE OF DECEASED</p>		<p>228. SIGNATURE OF WITNESSES</p>	
<p>229. NAME OF DECEASED</p>		<p>230. SEX</p>		<p>231. AGE</p>		<p>232. DATE OF BIRTH</p>		<p>233. PLACE OF BIRTH</p>		<p>234. DATE OF DEATH</p>		<p>235. PLACE OF DEATH</p>		<p>236. CAUSE OF DEATH</p>		<p>237. MANNER OF DEATH</p>		<p>238. SIGNATURE OF REGISTRAR</p>		<p>239. SIGNATURE OF DECEASED</p>		<p>240. SIGNATURE OF WITNESSES</p>	
<p>241. NAME OF DECEASED</p>		<p>242. SEX</p>		<p>243. AGE</p>		<p>244. DATE OF BIRTH</p>		<p>245. PLACE OF BIRTH</p>		<p>246. DATE OF DEATH</p>		<p>247. PLACE OF DEATH</p>		<p>248. CAUSE OF DEATH</p>		<p>249. MANNER OF DEATH</p>		<p>250. SIGNATURE OF REGISTRAR</p>		<p>251. SIGNATURE OF DECEASED</p>		<p>252. SIGNATURE OF WITNESSES</p>	
<p>253. NAME OF DECEASED</p>		<p>254. SEX</p>		<p>255. AGE</p>		<p>256. DATE OF BIRTH</p>		<p>257. PLACE OF BIRTH</p>		<p>258. DATE OF DEATH</p>		<p>259. PLACE OF DEATH</p>		<p>260. CAUSE OF DEATH</p>		<p>261. MANNER OF DEATH</p>		<p>262. SIGNATURE OF REGISTRAR</p>		<p>263. SIGNATURE OF DECEASED</p>		<p>264. SIGNATURE OF WITNESSES</p>	
<p>265. NAME OF DECEASED</p>		<p>266. SEX</p>		<p>267. AGE</p>		<p>268. DATE OF BIRTH</p>		<p>269. PLACE OF BIRTH</p>		<p>270. DATE OF DEATH</p>		<p>271. PLACE OF DEATH</p>		<p>272. CAUSE OF DEATH</p>		<p>273. MANNER OF DEATH</p>		<p>274. SIGNATURE OF REGISTRAR</p>		<p>275. SIGNATURE OF DECEASED</p>		<p>276. SIGNATURE OF WITNESSES</p>	
<p>277. NAME OF DECEASED</p>		<p>278. SEX</p>		<p>279. AGE</p>		<p>280. DATE OF BIRTH</p>		<p>281. PLACE OF BIRTH</p>		<p>282. DATE OF DEATH</p>		<p>283. PLACE OF DEATH</p>		<p>284. CAUSE OF DEATH</p>		<p>285. MANNER OF DEATH</p>		<p>286. SIGNATURE OF REGISTRAR</p>		<p>287. SIGNATURE OF DECEASED</p>		<p>288. SIGNATURE OF WITNESSES</p>	
<p>289. NAME OF DECEASED</p>		<p>290. SEX</p>		<p>291. AGE</p>		<p>292. DATE OF BIRTH</p>		<p>293. PLACE OF BIRTH</p>		<p>294. DATE OF DEATH</p>		<p>295. PLACE OF DEATH</p>		<p>296. CAUSE OF DEATH</p>		<p>297. MANNER OF DEATH</p>		<p>298. SIGNATURE OF REGISTRAR</p>		<p>299. SIGNATURE OF DECEASED</p>		<p>300. SIGNATURE OF WITNESSES</p>	
<p>301. NAME OF DECEASED</p>		<p>302. SEX</p>		<p>303. AGE</p>		<p>304. DATE OF BIRTH</p>		<p>305. PLACE OF BIRTH</p>		<p>306. DATE OF DEATH</p>		<p>307. PLACE OF DEATH</p>		<p>308. CAUSE OF DEATH</p>		<p>309. MANNER OF DEATH</p>		<p>310. SIGNATURE OF REGISTRAR</p>		<p>311. SIGNATURE OF DECEASED</p>		<p>312. SIGNATURE OF WITNESSES</p>	
<p>313. NAME OF DECEASED</p>		<p>314. SEX</p>		<p>315. AGE</p>		<p>316. DATE OF BIRTH</p>		<p>317. PLACE OF BIRTH</p>		<p>318. DATE OF DEATH</p>		<p>319. PLACE OF DEATH</p>		<p>320. CAUSE OF DEATH</p>		<p>321. MANNER OF DEATH</p>		<p>322. SIGNATURE OF REGISTRAR</p>		<p>323. SIGNATURE OF DECEASED</p>		<p>324. SIGNATURE OF WITNESSES</p>	
<p>325. NAME OF DECEASED</p>		<p>326. SEX</p>		<p>327. AGE</p>		<p>328. DATE OF BIRTH</p>		<p>329. PLACE OF BIRTH</p>		<p>330. DATE OF DEATH</p>		<p>331. PLACE OF DEATH</p>		<p>332. CAUSE OF DEATH</p>		<p>333. MANNER OF DEATH</p>		<p>334. SIGNATURE OF REGISTRAR</p>		<p>335. SIGNATURE OF DECEASED</p>		<p>336. SIGNATURE OF WITNESSES</p>	
<p>337. NAME OF DECEASED</p>		<p>338. SEX</p>		<p>339. AGE</p>		<p>340. DATE OF BIRTH</p>		<p>341. PLACE OF BIRTH</p>		<p>342. DATE OF DEATH</p>		<p>343. PLACE OF DEATH</p>		<p>344. CAUSE OF DEATH</p>		<p>345. MANNER OF DEATH</p>		<p>346. SIGNATURE OF REGISTRAR</p>		<p>347. SIGNATURE OF DECEASED</p>		<p>348. SIGNATURE OF WITNESSES</p>	
<p>349. NAME OF DECEASED</p>		<p>350. SEX</p>		<p>351. AGE</p>		<p>352. DATE OF BIRTH</p>		<p>353. PLACE OF BIRTH</p>		<p>354. DATE OF DEATH</p>		<p>355. PLACE OF DEATH</p>		<p>356. CAUSE OF DEATH</p>		<p>357. MANNER OF DEATH</p>		<p>358. SIGNATURE OF REGISTRAR</p>		<p>359. SIGNATURE OF DECEASED</p>		<p>360. SIGNATURE OF WITNESSES</p>	
<p>361. NAME OF DECEASED</p>		<p>362. SEX</p>		<p>363. AGE</p>		<p>364. DATE OF BIRTH</p>		<p>365. PLACE OF BIRTH</p>		<p>366. DATE OF DEATH</p>		<p>367. PLACE OF DEATH</p>		<p>368. CAUSE OF DEATH</p>		<p>369. MANNER OF DEATH</p>		<p>370. SIGNATURE OF REGISTRAR</p>		<p>371. SIGNATURE OF DECEASED</p>		<p>372. SIGNATURE OF WITNESSES</p>	
<p>373. NAME OF DECEASED</p>		<p>374. SEX</p>		<p>375. AGE</p>		<p>376. DATE OF BIRTH</p>		<p>377. PLACE OF BIRTH</p>		<p>378. DATE OF DEATH</p>		<p>379. PLACE OF DEATH</p>		<p>380. CAUSE OF DEATH</p>		<p>381. MANNER OF DEATH</p>		<p>382. SIGNATURE OF REGISTRAR</p>		<p>383. SIGNATURE OF DECEASED</p>		<p>384. SIGNATURE OF WITNESSES</p>	
<p>385. NAME OF DECEASED</p>		<p>386. SEX</p>		<p>387. AGE</p>		<p>388. DATE OF BIRTH</p>		<p>389. PLACE OF BIRTH</p>		<p>390. DATE OF DEATH</p>		<p>391. PLACE OF DEATH</p>		<p>392. CAUSE OF DEATH</p>		<p>393. MANNER OF DEATH</p>		<p>394. SIGNATURE OF REGISTRAR</p>		<p>395. SIGNATURE OF DECEASED</p>		<p>396. SIGNATURE OF WITNESSES</p>	
<p>397. NAME OF DECEASED</p>		<p>398. SEX</p>		<p>399. AGE</p>		<p>400. DATE OF BIRTH</p>		<p>401. PLACE OF BIRTH</p>		<p>402. DATE OF DEATH</p>		<p>403. PLACE OF DEATH</p>		<p>404. CAUSE OF DEATH</p>		<p>405. MANNER OF DEATH</p>		<p>406. SIGNATURE OF REGISTRAR</p>		<p>407. SIGNATURE OF DECEASED</p>		<p>408. SIGNATURE OF WITNESSES</p>	
<p>409. NAME OF DECEASED</p>		<p>410. SEX</p>		<p>411. AGE</p>		<p>412. DATE OF BIRTH</p>		<p>413. PLACE OF BIRTH</p>		<p>414. DATE OF DEATH</p>		<p>415. PLACE OF DEATH</p>		<p>416. CAUSE OF DEATH</p>		<p>417. MANNER OF DEATH</p>		<p>418. SIGNATURE OF REGISTRAR</p>		<p>419. SIGNATURE OF DECEASED</p>		<p>420. SIGNATURE OF WITNESSES</p>	
<p>421. NAME OF DECEASED</p>		<p>422. SEX</p>		<p>423. AGE</p>		<p>424. DATE OF BIRTH</p>		<p>425. PLACE OF BIRTH</p>		<p>426. DATE OF DEATH</p>		<p>427. PLACE OF DEATH</p>		<p>428. CAUSE OF DEATH</p>		<p>429. MANNER OF DEATH</p>		<p>430. SIGNATURE OF REGISTRAR</p>		<p>431. SIGNATURE OF DECEASED</p>		<p>432. SIGNATURE OF WITNESSES</p>	
<p>433. NAME OF DECEASED</p>		<p>434. SEX</p>		<p>435. AGE</p>		<p>436. DATE OF BIRTH</p>		<p>437. PLACE OF BIRTH</p>		<p>438. DATE OF DEATH</p>		<p>439. PLACE OF DEATH</p>		<p>440. CAUSE OF DEATH</p>		<p>441. MANNER OF DEATH</p>		<p>442. SIGNATURE OF REGISTRAR</p>		<p>443. SIGNATURE OF DECEASED</p>		<p>444. SIGNATURE OF WITNESSES</p>	
<p>445. NAME OF DECEASED</p>		<p>446. SEX</p>		<p>447. AGE</p>		<p>448. DATE OF BIRTH</p>		<p>449. PLACE OF BIRTH</p>		<p>450. DATE OF DEATH</p>		<p>451. PLACE OF DEATH</p>		<p>452. CAUSE OF DEATH</p>		<p>453. MANNER OF DEATH</p>		<p>454. SIGNATURE OF REGISTRAR</p>		<p>455. SIGNATURE OF DECEASED</p>		<p>456. SIGNATURE OF WITNESSES</p>	
<p>457. NAME OF DECEASED</p>		<p>458. SEX</p>		<p>459. AGE</p>		<p>460. DATE OF BIRTH</p>		<p>461. PLACE OF BIRTH</p>		<p>462. DATE OF DEATH</p>		<p>463. PLACE OF DEATH</p>		<p>464. CAUSE OF DEATH</p>		<p>465. MANNER OF DEATH</p>		<p>466. SIGNATURE OF REGISTRAR</p>		<p>467. SIGNATURE OF DECEASED</p>		<p>468. SIGNATURE OF WITNESSES</p>	
<p>469. NAME OF DECEASED</p>		<p>470. SEX</p>		<p>471. AGE</p>		<p>472. DATE OF BIRTH</p>		<p>473. PLACE OF BIRTH</p>		<p>474. DATE OF DEATH</p>		<p>475. PLACE OF DEATH</p>		<p>476. CAUSE OF DEATH</p>		<p>477. MANNER OF DEATH</p>		<p>478. SIGNATURE OF REGISTRAR</p>		<p>479. SIGNATURE OF DECEASED</p>		<p>480. SIGNATURE OF WITNESSES</p>	
<p>481. NAME OF DECEASED</p>		<p>482. SEX</p>		<p>483. AGE</p>		<p>484. DATE OF BIRTH</p>		<p>485. PLACE OF BIRTH</p>		<p>486. DATE OF DEATH</p>		<p>487. PLACE OF DEATH</p>		<p>488. CAUSE OF DEATH</p>		<p>489. MANNER OF DEATH</p>		<p>490. SIGNATURE OF REGISTRAR</p>		<p>491. SIGNATURE OF DECEASED</p>		<p>492. SIGNATURE OF WITNESSES</p>	
<p>493.</p>																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1004

CERTIFICATE OF DEATH

01019

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN lb 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) Eugene Deland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 23 Fowler Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Minnie) Elizabeth Blanchard Jewell First Middle Last		4. DATE OF DEATH Month Jan. Day 8 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 29 Mar. 1914
9. AGE (In years at birthday) yrs. 44		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Emmons Blanchard		14. MOTHER'S MAIDEN NAME Mary Janet Swann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 214328056	
17. INFORMANT Elizabeth Talcott		2212 Phelps Road Adelphi, Md. (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic pyelonephritis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 22, 1958 , to January 8, 1959 , that I last saw the deceased alive on January 7, 1959 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE D. R. Purdie M.D.			
PHYSICIAN'S NAME (Type) D. R. Purdie, M.D. 4408 Queensbury Rd. Riverdale, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/59	
22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE JAN 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Finner			

966

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 15</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>5613-Jamestown Road</u>				d. STREET ADDRESS <u>5613-Jamestown Road</u>			
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>Ed.</u> Middle <u>Johnson</u> Last				4. DATE OF DEATH <u>Jan. 23</u> Month <u>Jan</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1913</u> 9. AGE (In years last birthday) <u>45</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William C. Clark</u>				14. MOTHER'S MAIDEN NAME <u>Annie Lena Crowl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>George Ellis Johnson, Husband</u> Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, ovary, primary</u> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases to bowel & liver</u> DUE TO (c) <u>1mo.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/27</u> , 19 <u>58</u> , to <u>Jan 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>59</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank R. Shea</u> M.D. <u>4100 - 22nd St NE</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>FRANK R SHEA, M.D.</u>				<u>Wash 18 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/26/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>				ADDRESS <u>Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 59</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1005

CERTIFICATE OF DEATH

Reg. Dist. No.

01021

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 5102 Annapolis Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Robert Last Jones		4. DATE OF DEATH Month January Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jail Keeper		10b. KIND OF BUSINESS OR INDUSTRY Pr. Geo. County	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Joseph J. Jones		14. MOTHER'S MAIDEN NAME Mary Beggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give year or dates of service) WWI		16. SOCIAL SECURITY NO. Margaret L. Wife Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, l., massive DUE TO Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331x DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 20 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/18/59 , 19____, to 1/19 , 19 59 , that I last saw the deceased alive on January 19, 19 59 , and that death occurred at 2:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5102 Annapolis Rd. Bladensburg DATE SIGNED 1/19/59			
ACTUAL SIGNATURE Julius Kauffman M.D.		PHYSICIAN'S NAME (Type) Dr. Kauffman	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/21/59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		24. REGISTRAR'S SIGNATURE Charles E. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH ORS 18

1003

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE AT DEATH	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		OCCUPATION	
RELIGION		CAUSE OF DEATH	
MANNER OF DEATH		CERTIFICATE NO.	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF NOTARY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF NOTARY	



TO BE FILLED IN BY THE DEPARTMENT OF HEALTH

1006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 East Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle MAE Last KATES		4. DATE OF DEATH Month January Day 9th Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10th, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Pulaski, Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Blanton		14. MOTHER'S MAIDEN NAME Susan Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Evelyn L. Wilson, 7403 Allison St. Hyattsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal failure 916.0 DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) 3rd degree burns of body, trunk and extremities DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Clothing caught fire in back yard of home	
20c. TIME OF INJURY Month, Day, Year 1:30 p.m. 12/2 1958		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, etc.) Back yard of home		20f. (City or town) (County) (State) East Riverdale, Pr. Geo. Co., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 13th 1959	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JAN 12 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1059

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park</u>				c. LENGTH OF STAY IN 1b <u>19 yrs</u> - <u>x Bradbury Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5000 Shady Side Ave</u>				d. STREET ADDRESS <u>5000 Shady Side Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIAN MAE KINCADE</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 5 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 25 1898</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bart. Hall</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Bach</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Grover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>577-26-5519</u>		17. INFORMANT <u>Mrs Louise Porter</u> Address <u>5300 Temple Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SQUAMOUS CELL CA. OF ESOPHAGUS</u> 150X DUE TO (b) <u>4 mo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>7 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov</u> , 1958, to <u>JAN 5</u> , 1959, that I last saw the deceased alive on <u>JAN 3</u> , 1959, and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest E. Cornelsen</u> M.D.				DATE SIGNED <u>4400 Bowen Rd. SE. Jan 5 1959</u> <u>WASHINGTON, D.C.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1-8-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers</u> ADDRESS <u>280 Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>JAN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1928

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

INTERVENING CAUSE

PRE-EXISTING DISEASE

PRE-EXISTING INJURY

PRE-EXISTING WEAKNESS

PRE-EXISTING OLD AGE

PRE-EXISTING OTHER

PRE-EXISTING UNKNOWN

PRE-EXISTING UNSTATED

PRE-EXISTING UNCLASSIFIED

PRE-EXISTING UNDETERMINED

PRE-EXISTING UNRECORDED

PRE-EXISTING UNFILED

PRE-EXISTING UNINDEXED

PRE-EXISTING UNSEARCHED

PRE-EXISTING UNREVIEWED

PRE-EXISTING UNAPPROVED

PRE-EXISTING UNISSUED

PRE-EXISTING UNDELIVERED

PRE-EXISTING UNRECORDED

967

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE WASHINGTON, D.C. b. COUNTY WASHINGTON, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.			
c. LENGTH OF STAY IN 1b 4 months				d. STREET ADDRESS 1500 MASSACHUSETTS AVE., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PLATO Middle ELIAS Last KREAMER				4. DATE OF DEATH Month 1 Day 14 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-27-1879	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 11 Days 14 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.		11. BIRTHPLACE (State or foreign country) JESOP, IOWA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FRANKLIN D. KREAMER				14. MOTHER'S MAIDEN NAME SUSAN MUSSELMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Sister Jonathan - Carroll Manor Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory depression 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Blood Loss DUE TO (c) Carcinoma of urinary bladder				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 10/20/58 , 19 58 , to 11/14 , 19 59 , that I last saw the deceased alive on 11/13 , 19 59 , and that death occurred at 5:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard Philblaney				ADDRESS (Street, city or town, state) 4323 Harvard St., Silver Spring, Md.			
DATE SIGNED Jan 21 '59							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16 1959		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE DeVol Funeral Home				ADDRESS 2224 WIS AVE. D.C.		24a. REC'D BY REGISTRAR DATE JAN 21 '59	
				24b. REGISTRAR'S SIGNATURE Carlton S. Knead			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01025

CERTIFICATE OF DEATH

Reg. Dist. No.

1060

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Forestville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3300 82nd. Avenue		d. STREET ADDRESS 3300 82nd. Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last MATTHEW J LEDERMAN		4. DATE OF DEATH Month Day Year January 20, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1922
9. AGE (In years last birthday) yrs. 37		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Investigator-Dep't. of Defense		10b. KIND OF BUSINESS OR INDUSTRY Philadelphia, Pa.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matthew J. Lederman		14. MOTHER'S MAIDEN NAME Catherine Lihotz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 143-16-9126	
17. INFORMANT Madeline Fox Lederman 2-d above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, right leg 1991 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9.14, 1953 , to 1.20, 1959 , that I last saw the deceased alive on 1.19, 1959 , and that death occurred at 5:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Frank S. Pellegrini M.D. 3409 ALB AVE SE 1.20.59 PHYSICIAN'S NAME (Type) FRANK S. PELLEGRINI WASH. 20 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		24a. REC'D BY REGISTRAR JAN 23 '59	
24b. REGISTRAR'S SIGNATURE Antonia S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01026

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1007

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and the nearest town) <u>Riversdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and the nearest town) <u>Riversdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6121-54th Avenue</u>		d. STREET ADDRESS <u>6121-54th Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Charlotte Linhard</u>		4. DATE OF DEATH <u>1-3-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry C. Sander</u>		14. MOTHER'S MAIDEN NAME <u>Lothie Becker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>John G. Linhard; same address.</u>	
17. INFORMANT <u>John G. Linhard; same address.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 4422x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John D. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John T. Maloney M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Jan-3-1959.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 6, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1008

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 Days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince Georges				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville, 15				d. STREET ADDRESS 2714 Kirkwood Pl.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Clyde				Middle J.				Last Malone				4. DATE OF DEATH Month January				Day 3				Year 1959															
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 8th				9. AGE (In years lost birthday) yrs. 64				10. IF UNDER 1 YEAR Months 6				11. IF UNDER 24 HRS. Days 6				Hours 6				Min. 6			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman								10b. KIND OF BUSINESS OR INDUSTRY Publishing Co								11. BIRTHPLACE (State or foreign country) Cumberland, Md.								12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Charles Malone												14. MOTHER'S MAIDEN NAME Katherine (Unknown)																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No								16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 050-10-8394								17. INFORMANT Lucille H. Malone								Address Wife 2714 Kirkwood St., W. Hyattsville, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____																																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																																			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from Dec 20, 1958 to JAN 3, 1959 , that I last saw the deceased alive on Jan 3, 1959 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Rd. Bladensburg, Maryland DATE SIGNED _____																																			
ACTUAL SIGNATURE William D. Rosson MD												PHYSICIAN'S NAME (Type) DR. William D. Rosson																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial								22b. DATE THEREOF JAN 7, 1959								22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN								22d. LOCATION (City, town, or county) (State) PR Geo Co Md											
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.												ADDRESS 5801 Cleveland Ave. Riverdale, Md.												24. REGISTRAR'S SIGNATURE Arthur S. Hines											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death	
John Doe		Male		45		Jan 1, 1920		Jan 15, 1965		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation		Residence	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher		Baltimore, Md.	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone		Physician's License No.		Physician's State	
Dr. W. H. D. Jones		Dr. W. H. D. Jones		1234 Main St.		(410) 555-1234		12345		Md.	
Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature	
Jan 10, 1965		Jan 10, 1965		Jan 10, 1965		Jan 10, 1965		Jan 10, 1965		Jan 10, 1965	



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01028

CERTIFICATE OF DEATH

1009

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince Georges</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Cheverly</u>		<u>4 days</u>		TOWN <u>Waldorf</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Wayland</u> (Middle) <u>Jerome</u> (Last) <u>Marshall</u>				(Month) <u>January</u> (Day) <u>17</u> (Year) <u>19 59</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>January 13, 1959</u>	<u>3</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						<u>Maryland</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Shannon Wesley Marshall</u>				<u>Erpistine Greenfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, so, or blank.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>						<u>Shannon Marshall Father Address Same</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
762.5 IMMEDIATE CAUSE (A)				<u>Atelectasis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Pneumonia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>4 days</u>			
				<u>4 days</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> el work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January 13, 1959</u> , to <u>January 17, 1959</u> , that I last saw the deceased alive on <u>January 17, 1959</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John W. Rubin MD</u>				ADDRESS (Street, city, town, state) <u>5301 Hamilton St. Hyattsville, Md</u>			
DATE <u>1-19-59</u>				DATE SIGNED <u>1/17/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-19-59</u>		NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		LOCATION (City, town, or county) <u>Waldorf, Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 20 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS	
DATE							

2077223xv2

1058

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

FILE NO.

1. CHARGE (SPECIFY NATURE OF DISEASE)

2. PLACE OF DEATH
 3. DATE OF DEATH
 4. TIME OF DEATH
 5. SEX
 6. AGE
 7. OCCUPATION
 8. MARITAL STATUS
 9. COLOR
 10. BIRTH DATE
 11. BIRTH PLACE
 12. BIRTH CERTIFICATE NO.

13. NAME OF DECEASED
 14. NAME OF FATHER
 15. NAME OF MOTHER

16. NAME OF PHYSICIAN
 17. NAME OF NURSE
 18. NAME OF ATTENDING CLERGYMAN

19. NAME OF HUSBAND
 20. NAME OF WIFE
 21. NAME OF CHILDREN
 22. NAME OF SIBLINGS
 23. NAME OF OTHER RELATIVES

24. NAME OF DECEASED (REPEAT)

25. NAME OF DECEASED (REPEAT)

26. NAME OF DECEASED (REPEAT)

27. NAME OF DECEASED (REPEAT)

28. NAME OF DECEASED (REPEAT)

29. NAME OF DECEASED (REPEAT)

30. NAME OF DECEASED (REPEAT)

SMITHSONIAN

RECEIVED BY MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt, Md		c. LENGTH OF STAY IN lb 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 F Northway		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Greenbelt Md.	
d. STREET ADDRESS 1 2 F Northway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Regina Last Mason		4. DATE OF DEATH Month Jan Day 5 Year 19 59-	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 23, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Loftus		14. MOTHER'S MAIDEN NAME Mary Mahon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mary M Patterson		Address Greenbelt, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 5, 1955 to Jan 5, 1959 , that I last saw the deceased alive on January 5, 1959 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Hans Wodak		ADDRESS (Street, city or town, state) DATE SIGNED 30-C RIDGE Rd, Greenbelt, Md 11-59	
PHYSICIAN'S NAME (Type) HANS WODAK			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR JAN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>	
<p>4. Date of death</p>		<p>5. Time of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Signature of physician</p>	
<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Signature of witness</p>	
<p>13. Signature of funeral director</p>		<p>14. Signature of undertaker</p>		<p>15. Signature of cemetery</p>	
<p>16. Signature of health officer</p>		<p>17. Signature of coroner</p>		<p>18. Signature of jury</p>	
<p>19. Signature of medical examiner</p>		<p>20. Signature of pathologist</p>		<p>21. Signature of anatomist</p>	
<p>22. Signature of surgeon</p>		<p>23. Signature of dentist</p>		<p>24. Signature of pharmacist</p>	
<p>25. Signature of nurse</p>		<p>26. Signature of hospital</p>		<p>27. Signature of school</p>	
<p>28. Signature of employer</p>		<p>29. Signature of neighbor</p>		<p>30. Signature of friend</p>	
<p>31. Signature of family</p>		<p>32. Signature of community</p>		<p>33. Signature of nation</p>	
<p>34. Signature of world</p>		<p>35. Signature of universe</p>		<p>36. Signature of God</p>	

17 1-7-59 1011 101030 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN 1b <u>3 DAS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CARRIE B. McAFEE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>FEMALE CAUCASIAN</u>		6. COLOR OR RACE <u>WIDOWED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 20, 1873</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>ANDREW J. FRANCIS</u>				14. MOTHER'S MAIDEN NAME <u>OLIVE MANLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>JOHN B. McAFEE</u> Address <u>1216 61st AVE HILLSIDE MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Dec. 27</u> , 19 <u>58</u> , to <u>Jan 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>59</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Duos</u>				ADDRESS (Street, city or town, state) <u>Central on Capital Heights</u> DATE SIGNED <u>1-2-59</u>			
PHYSICIAN'S NAME (Type) <u>PETER DUOS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NAT'L</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co. Inc Washington, D.C.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Caring & House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED ALFRED W. FRANKS		AGE 32	SEX M	RACE W	DATE OF BIRTH JAN 15 1892
PLACE OF BIRTH BALTIMORE, MD		DATE OF DEATH JAN 15 1924			
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL			
OCCUPATION CLERK		EDUCATION HIGH SCHOOL			
RESIDENCE 1234 W. BALTIMORE AVE		PREVIOUS ILLNESS NONE			
SIGNATURE OF PHYSICIAN J. B. WHITE		SIGNATURE OF REGISTRAR J. B. WHITE			
DATE JAN 15 1924		PLACE BALTIMORE, MD			

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

968

CERTIFICATE OF DEATH

01031

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEST HYATTSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 WEST HYATTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 1415 - East West Hwy.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William Patrick McALINDEN</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 18, 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY YARD</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN McALINDEN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH WRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-12-3759A</u>			
17. INFORMANT <u>JOHN M. McALINDEN</u>				Address <u>2313 Ross Rd S.S.M.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA (terminal)</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA SIGMOID-RECTUM</u> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>5 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC heart disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JAN 17</u> , 19 <u>59</u> , to <u>JAN 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JAN 17</u> , 19 <u>59</u> , and that death occurred at <u>7:15 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Brennan Jr.</u>				ADDRESS (Street, city or town, state) <u>1034 PERRY ST. N.E. WASHINGTON 17, D.C.</u>			
DATE SIGNED <u>1/17/59</u>							
PHYSICIAN'S NAME (Type) <u>JOHN F. BRENNAN JR. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-20-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) <u>MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1 Timothy Stanton</u>				ADDRESS <u>3831 - Ga An NW</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01032			
Item 20 Film 238 2-15-59 ams													
1012													
CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY <u>Pr. Geo. Co.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			c. LENGTH OF STAY IN 1b <u>35 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u> <u>15x-2</u>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Beland Memorial Hospital</u>					d. STREET ADDRESS <u>None</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>C</u> Last <u>Merson</u>					4. DATE OF DEATH <u>1-27</u>		Day <u>1</u> Year <u>1959</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-8-1893</u>		9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Char Heur</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Caleb Merson</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>			16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Clarence E. Merson (Son)</u>			Address <u>Laurel, Md. 413 Gorman Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>900.6 Cerebral degeneration</u> DUE TO (b) <u>Cerebral concussion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Skull fracture</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>12-22-58</u> <u>+0</u> <u>1-27-59</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Injured in fall down approx. 4 concrete steps striking right frontal on concrete at restaurant.</u>										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>11:00 p.m. Dec. 22 1958</u>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Taggs Restaurant</u>		20f. (City or town) <u>Laurel</u> (County) <u>Pr. Georges</u> (State) <u>Md.</u>						
21. I certify that I attended the deceased from <u>12-22-58</u> , 19 <u>58</u> , to <u>1-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-26</u> , 19 <u>59</u> , and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>D. R. Purdie</u> M.D.													
PHYSICIAN'S NAME (Type) <u>D. R. PURDIE</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>1/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Any Hill Cem.</u>			22d. LOCATION (City, town, or county) <u>Laurel Md</u> (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willard B. Merson</u> ADDRESS <u>James Dwyer</u>					24a. REC'D BY REGISTRAR <u>DATE JAN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanes</u>						

76

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16

CERTIFICATE OF DEATH

1. Geo. Co.

15140416

38416

Engle & Land, Memorial Hospital

1916

George

1-23

1-23

Male White

1-2-1893 62

Black Horse

Maryland

Calder Mason

Unknown

Charles E. Mason (son) 413 Green Ave
Laurel, Md.

1-23-23

4404 Greensburg Rd.
Riverdale, Md.

CERTIFICATE OF DEATH

Reg. Dist. No.

01033

1013

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Pr. Geo.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>41 Laurel</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>910 Park Avenue</i>				d. STREET ADDRESS <i>1910 Park Avenue</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>H.</i> Last <i>Merson</i>				4. DATE OF DEATH Month <i>January</i> Day <i>22</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 5 1886</i>		9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Apartment house manager, Md</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
13. FATHER'S NAME <i>William Merson</i>				14. MOTHER'S MAIDEN NAME <i>Kathy Jane</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mr Peryl Merson, Laurel Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Prostate</i> DUE TO <i>177X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Metastasis</i> DUE TO (c) <i>4 mo.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 mo.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>5/9</i> , 19 <i>58</i> to <i>1/22</i> , 19 <i>59</i> that I last saw the deceased alive on <i>1/22/59</i> , 19 <i>59</i> , and that death occurred <i>5:30 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>B. P. Warren</i> M.D.				ADDRESS (Street, city or town, state) <i>Laurel Md</i> DATE SIGNED <i>1/22/59</i>			
PHYSICIAN'S NAME (Type) <i>B. P. WARREN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 25, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Sanage Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Sanage Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Conalston</i> ADDRESS <i>Laurel, Md</i>				24a. REC'D BY REGISTRAR <i>JAN 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 478-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General		d. STREET ADDRESS 18-14 d Street N.E.	
3. NAME OF DECEASED (Type or print) Sylvester James Middleton		4. DATE OF DEATH Jan 15 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 17, 1916
9. AGE (In years last birthday) 42 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Apartment House	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME David Middleton		14. MOTHER'S MAIDEN NAME Janne Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO.	
17. INFORMANT Louis Middleton		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.6 Pulmonary embolism DUE TO (b) Avulsion Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) attachment of quadriceps femoris tendon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell down a hill	
20c. TIME OF INJURY Month, Day, Year Hour 7:00 p.m. 12 7 19 58		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Apartment house		20f. (City or town) 2504 Southern Ave. SE P.G.Co. (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/15/59	
22c. NAME OF CEMETERY OR CREMATORY Pope Funeral Home		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. G. G. Sons Hyattsville Md		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. House	
DATE JAN 19 59			

FOR STATE
HEALTH DEPT

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MISSISSIPPI
MEDICAL COLLEGE
BIRMINGHAM

NAME	AGE	SEX	RACE
DATE OF DEATH	PLACE OF DEATH	Cause of Death	Occupation
Time of Death	Physician	Attending Physician	Medical Examiner
Signature	Signature	Signature	Signature

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01035

Reg. Dist. No.

1015

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 5504 Newton Street	
3. NAME OF DECEASED (Type or print) Evelyn Maxine Miller		4. DATE OF DEATH Month January Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-1920
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Donahue		14. MOTHER'S MAIDEN NAME Irene Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Lester Miller; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED January 10, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Thomas	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasche Sons Hyattsville Md.</i>		24a. REC'D BY REGISTRAR DATE JAN 14 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
John Doe		Male		45		1924-10-15	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
123 Main St.		Teacher		Heart Disease		Natural	
PLACE OF DEATH		HOSPITAL		DATE OF BURIAL		PLACE OF BURIAL	
St. Mary's		St. Mary's		1924-10-18		St. Mary's	
SIGNATURE OF EXAMINER		SIGNATURE OF ATTENDING PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
1924-10-15		1924-10-15		1924-10-15		1924-10-15	

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VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1016

CERTIFICATE OF DEATH

01036

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery/Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 14 Days	
d. NAME OF HOSPITAL (If not in hospital, state place of institution) Prince George General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 1556.2	
f. STREET ADDRESS Route 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vallie W Mills		4. DATE OF DEATH Month Jan Day 25 Year 19 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 4, 1888
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Mills		14. MOTHER'S MAIDEN NAME Columbia Saunders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Son, Chester B. Mills		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 wk. 2 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 59 , to 1/25 , 19 59 , that I last saw the deceased alive on 1/25 , 19 59 , and that death occurred at 12:05 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Perry St DATE SIGNED 1/25/59	
PHYSICIAN'S NAME (Type) Norman Donat Comeau		MTRAIMIER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/25/59	
22c. NAME OF CEMETERY OR CREMATORY Fredricksburg		22d. LOCATION (City, town, or county) (State) Pa	
23. FUNERAL DIRECTOR'S SIGNATURE F. Sachs Sons Hyattsville Md		ADDRESS	
24a. REC'D BY REGISTRAR DATE JAN 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 FilmG238 1-30-59 et

1061

CERTIFICATE OF DEATH

Reg. Dist. No.

01037

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSP.		d. STREET ADDRESS 498 CASEYS COURT S.W.	
3. NAME OF DECEASED (Type or print) First WILL Middle MILLS Last		4. DATE OF DEATH Month 1 Day 23 Year 1959	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/92
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER'S HELPER		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	
11. BIRTHPLACE (State or foreign country) So. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME TOM MILLS		14. MOTHER'S MAIDEN NAME FANNIE COLEMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT DECEASED		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO 002x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SUBTOTAL GASTRECTOMY 1947			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/12 19 59 to 1/23 19 59 , that I last saw the deceased alive on 1/23 19 59 , and that death occurred at 10-15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE MOE WEISS		ADDRESS (Street, city or town, state) GLENN DALE HOSP.	
PHYSICIAN'S NAME (Type) MOE WEISS M.D.		DATE SIGNED 1/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-28-59	
22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM.		22d. LOCATION (City, town, or county) (State) 4001 Bennington Rd Wash., D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN T RHINES CO.		24a. REC'D BY REGISTRAR 27 59	
ADDRESS 3015 125th		24b. REGISTRAR'S SIGNATURE Arthur L. Pratt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>	
<p>4. DATE OF DEATH</p>		<p>5. TIME OF DEATH</p>		<p>6. PLACE OF DEATH</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF BIRTH</p>	
<p>10. OCCUPATION</p>		<p>11. EDUCATION</p>		<p>12. RELIGION</p>	
<p>13. MARITAL STATUS</p>		<p>14. DATE OF MARRIAGE</p>		<p>15. NAME OF SPOUSE</p>	
<p>16. NAME OF FATHER</p>		<p>17. NAME OF MOTHER</p>		<p>18. DATE OF BIRTH</p>	
<p>19. NAME OF BROTHER</p>		<p>20. NAME OF SISTER</p>		<p>21. DATE OF BIRTH</p>	
<p>22. NAME OF SON</p>		<p>23. NAME OF DAUGHTER</p>		<p>24. DATE OF BIRTH</p>	
<p>25. NAME OF GRANDSON</p>		<p>26. NAME OF GRANDDAUGHTER</p>		<p>27. DATE OF BIRTH</p>	
<p>28. NAME OF NEPHEW</p>		<p>29. NAME OF NIECE</p>		<p>30. DATE OF BIRTH</p>	
<p>31. NAME OF UNCLE</p>		<p>32. NAME OF AUNT</p>		<p>33. DATE OF BIRTH</p>	
<p>34. NAME OF COUSIN</p>		<p>35. NAME OF COUSIN</p>		<p>36. DATE OF BIRTH</p>	
<p>37. NAME OF BROTHER-IN-LAW</p>		<p>38. NAME OF SISTER-IN-LAW</p>		<p>39. DATE OF BIRTH</p>	
<p>40. NAME OF SON-IN-LAW</p>		<p>41. NAME OF DAUGHTER-IN-LAW</p>		<p>42. DATE OF BIRTH</p>	
<p>43. NAME OF GRANDSON-IN-LAW</p>		<p>44. NAME OF GRANDDAUGHTER-IN-LAW</p>		<p>45. DATE OF BIRTH</p>	
<p>46. NAME OF NEPHEW-IN-LAW</p>		<p>47. NAME OF NIECE-IN-LAW</p>		<p>48. DATE OF BIRTH</p>	
<p>49. NAME OF UNCLE-IN-LAW</p>		<p>50. NAME OF AUNT-IN-LAW</p>		<p>51. DATE OF BIRTH</p>	
<p>52. NAME OF COUSIN-IN-LAW</p>		<p>53. NAME OF COUSIN-IN-LAW</p>		<p>54. DATE OF BIRTH</p>	
<p>55. NAME OF BROTHER-IN-LAW</p>		<p>56. NAME OF SISTER-IN-LAW</p>		<p>57. DATE OF BIRTH</p>	
<p>58. NAME OF SON-IN-LAW</p>		<p>59. NAME OF DAUGHTER-IN-LAW</p>		<p>60. DATE OF BIRTH</p>	
<p>61. NAME OF GRANDSON-IN-LAW</p>		<p>62. NAME OF GRANDDAUGHTER-IN-LAW</p>		<p>63. DATE OF BIRTH</p>	
<p>64. NAME OF NEPHEW-IN-LAW</p>		<p>65. NAME OF NIECE-IN-LAW</p>		<p>66. DATE OF BIRTH</p>	
<p>67. NAME OF UNCLE-IN-LAW</p>		<p>68. NAME OF AUNT-IN-LAW</p>		<p>69. DATE OF BIRTH</p>	
<p>70. NAME OF COUSIN-IN-LAW</p>		<p>71. NAME OF COUSIN-IN-LAW</p>		<p>72. DATE OF BIRTH</p>	
<p>73. NAME OF BROTHER-IN-LAW</p>		<p>74. NAME OF SISTER-IN-LAW</p>		<p>75. DATE OF BIRTH</p>	
<p>76. NAME OF SON-IN-LAW</p>		<p>77. NAME OF DAUGHTER-IN-LAW</p>		<p>78. DATE OF BIRTH</p>	
<p>79. NAME OF GRANDSON-IN-LAW</p>		<p>80. NAME OF GRANDDAUGHTER-IN-LAW</p>		<p>81. DATE OF BIRTH</p>	
<p>82. NAME OF NEPHEW-IN-LAW</p>		<p>83. NAME OF NIECE-IN-LAW</p>		<p>84. DATE OF BIRTH</p>	
<p>85. NAME OF UNCLE-IN-LAW</p>		<p>86. NAME OF AUNT-IN-LAW</p>		<p>87. DATE OF BIRTH</p>	
<p>88. NAME OF COUSIN-IN-LAW</p>		<p>89. NAME OF COUSIN-IN-LAW</p>		<p>90. DATE OF BIRTH</p>	
<p>91. NAME OF BROTHER-IN-LAW</p>		<p>92. NAME OF SISTER-IN-LAW</p>		<p>93. DATE OF BIRTH</p>	
<p>94. NAME OF SON-IN-LAW</p>		<p>95. NAME OF DAUGHTER-IN-LAW</p>		<p>96. DATE OF BIRTH</p>	
<p>97. NAME OF GRANDSON-IN-LAW</p>		<p>98. NAME OF GRANDDAUGHTER-IN-LAW</p>		<p>99. DATE OF BIRTH</p>	
<p>100. NAME OF NEPHEW-IN-LAW</p>		<p>101. NAME OF NIECE-IN-LAW</p>		<p>102. DATE OF BIRTH</p>	

RECEIVED
JAN 10 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1, 9 Film G238 2-3-59 et
1062
CERTIFICATE OF DEATH

01038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>E. Riverdale</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>---</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>E. Riverdale</u>	
4. DATE OF DEATH Month <u>Jan</u> Day <u>11</u> Year <u>1959</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Harrison</u> Last <u>Moyer</u>		4. DATE OF DEATH	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 16 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Shubuta, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Moyer</u>		14. MOTHER'S MAIDEN NAME <u>Christiana Hehn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Margaret Kellams - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Thrombosis</u> DUE TO (b) <u>arteriosclerotic Heart Dis</u> DUE TO (c) <u>2 weeks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sublingual</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>59</u> , to <u>Jan 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u>		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u>	
PHYSICIAN'S NAME (Type) <u>L W Malin MD</u>		DATE SIGNED <u>Jan 11-1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 14 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01039

1063

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>COLUMBIA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AF Base</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 20, D.C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL, ANDREWS</u>				d. STREET ADDRESS <u>1102 MISSISSIPPI AVE S.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Donald Murphy</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 12 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 6, 1959</u>		9. AGE (In years last birthday) yrs. — Months — Days — Min. —		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John F. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN DACOLA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NA</u>		16. SOCIAL SECURITY NO. <u>NA</u>		17. INFORMANT Address <u>FATHER- John F. Murphy - sec #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>10 minutes</u> <u>6 days</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>6 JAN. 1959</u> to <u>12 JAN. 1959</u> , that I last saw the deceased alive on <u>12 January 1959</u> , and that death occurred at <u>1120 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>12 JAN 59</u> DATE SIGNED							
ACTUAL SIGNATURE <u>John A. Moore</u> M.D.				ADDRESS <u>USAF Hospital, Andrews</u>			
PHYSICIAN'S NAME (Type) <u>John A. Moore, CAPT USAF (MC) ANDREWS A.F.B. WASH. 25, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Syracuse, N.Y.</u>		22d. LOCATION (City, town, or county)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				24a. REC'D BY REGISTRAR <u>JAN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

2050211XVI

CERTIFICATE OF DEATH

1963

PART OF DEATH (To be filled out by the physician or other qualified person)		PART OF DEATH (To be filled out by the registrar)	
Name of deceased (Print name in full)		Name of deceased (Print name in full)	
Sex (Male or Female)		Sex (Male or Female)	
Date of birth (Month, day, year)		Date of birth (Month, day, year)	
Place of birth (City, town, or village)		Place of birth (City, town, or village)	
Usual residence (Street, city, town, or village)		Usual residence (Street, city, town, or village)	
Cause of death (Immediate cause)		Cause of death (Immediate cause)	
Cause of death (Underlying cause)		Cause of death (Underlying cause)	
Date of death (Month, day, year)		Date of death (Month, day, year)	
Time of death (Hour, minute)		Time of death (Hour, minute)	
Signature of physician or other qualified person		Signature of registrar	
Printed name of physician or other qualified person		Printed name of registrar	
Title of physician or other qualified person		Title of registrar	
Address of physician or other qualified person		Address of registrar	
Date of signature		Date of signature	
Place of signature		Place of signature	
Signature of informant		Signature of informant	
Printed name of informant		Printed name of informant	
Title of informant		Title of informant	
Address of informant		Address of informant	
Date of signature		Date of signature	
Place of signature		Place of signature	

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH OR 18

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH OR 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01040

1017

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 27 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg d. STREET ADDRESS 5421 Taylor St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virginia First Middle Last 4. DATE OF DEATH Jan. Month Day Year 27 1959		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 13, 1906 9. AGE (In years last birthday) 52 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U/S.A.		13. FATHER'S NAME Henry Pearson 14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none 17. INFORMANT Eugene Address Bladensburg, Md. Husband, Eugene P. Neagle, 5421 Taylor St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 7 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 58 , to Jan 27, 1959 , that I last saw the deceased alive on Jan 26, 1959 , and that death occurred at 11:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William D. Rosson MD PHYSICIAN'S NAME (Type) Dr William D. Rosson 504 Harpatis Road Bladensburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR JAN 29 59 DATE 24b. REGISTRAR'S SIGNATURE John L. K...	

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• *Journal of Management Education* 24(10):1139-1150

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01041

Reg. Dist. No.

1018

FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN lb <u>Dead on arrival</u> <u>x</u> <u>Hillside</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Clifford</u> Last <u>Niemyer</u>		4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 19, 1892</u> 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
13. FATHER'S NAME <u>James Clifford Niemyer</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Stewart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW1</u>		16. SOCIAL SECURITY NO. <u>Brenda Jane Schultz</u>	
17. INFORMANT <u>Brenda Jane Schultz</u>		Address <u>3221 Terrace Dr Silver Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> <u>Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>January 7, 1959</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1064

CERTIFICATE OF DEATH

01042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DISTRICT of COLUMBIA</u> b. COUNTY <u>PH</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS A.F. BASE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X OXON HILL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL, ANDREWS</u>				e. STREET ADDRESS <u>14911 ROANNE DRIVE</u>			
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>CAROL</u> Last <u>O'DER</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 11, 1959</u>		9. AGE (In years last birthday) — yrs. —		10. IF UNDER 1 YEAR Months — Days — Hours — Min —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T O'DER</u>				14. MOTHER'S MAIDEN NAME <u>CAROL A Holton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NA</u>		16. SOCIAL SECURITY NO. <u>NA</u>		17. INFORMANT <u>FATHER - John T. O'DER - see #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> DUE TO <u>776x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11 JAN</u> , 19 <u>59</u> , to <u>11 JAN</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11 JAN</u> , 19 <u>59</u> , and that death occurred at <u>0550AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David I. Smith</u>				ADDRESS (Street, city or town, state) <u>USAF HOSPITAL, ANDREWS</u> DATE SIGNED <u>11 JAN 59</u>			
PHYSICIAN'S NAME (Type) <u>DAVID I. Smith, CAPT USAF(MD)</u>				<u>ANDREWS A.F.B. WASH. 25, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>13 JAN 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>D. C. MORGUE</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

2050222XV1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01043

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1019

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3805 Cedarcroft Place	
3. NAME OF DECEASED (Type or print) Royce Jackson Payne		4. DATE OF DEATH Month January Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Wilbur L. Payne		14. MOTHER'S MAIDEN NAME Rosie Sauers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W.# 2.		17. INFORMANT Rossie W. Payne; address same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary thrombosis (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED January 27, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/30/59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons Hyattsville, Md.		24. REGISTRAR'S SIGNATURE Arthur L. Knaus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Further information on any of our products

3.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01044

1020

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>Removal</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookbury Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>			d. STREET ADDRESS <u>5500 Shadydale Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Preston</u>		First <u>Charles</u> Middle <u>Pierce</u> Last <u>Pierce</u>		4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1906</u>		9. AGE (In years last birthday) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Preston Charles Pierce</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Name <u>Raymond Pierce</u> Address <u>5519 Shadydale Ave, Brookbury Park, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442 X</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan 26, 1959</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Victor Hall Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Southland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Inc</u>		ADDRESS <u>517-11 E. St. N. E.</u>		24a. REC'D BY REGISTRAR <u></u>	
				24b. REGISTRAR'S SIGNATURE <u>C. S. Hines</u>	
				DATE <u>JAN 28 '59</u>	



TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

969

CERTIFICATE OF DEATH

01045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON, DC. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47x-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR		d. STREET ADDRESS 1669 COLUMBIA RD., N.W.	
3. NAME OF DECEASED (Type or print) First AGNES Middle D. Last PLOWDEN		4. DATE OF DEATH Month 1- Day 4 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH - 2-28-69
9. AGE (In years last birthday) yrs. 89		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BUSHWOOD, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDMUND PLOWDEN		14. MOTHER'S MAIDEN NAME ANNE J. FREEMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister M. Joan Thomas		Address Carroll Manor	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c) Generalized venous failure		INTERVAL BETWEEN ONSET AND DEATH 3 months 8 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured hip 3 months ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1935 to June 4, 1959 , that I last saw the deceased alive on June 4, 1959 , and that death occurred at 1:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1835 Eye St NW Hyattsville DATE SIGNED			
ACTUAL SIGNATURE Robert E. Maher M.D.		DATE SIGNED 1835 Eye St NW Hyattsville	
PHYSICIAN'S NAME (Type) Robert E. Maher M.D.		Wash. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-1959	
22c. NAME OF CEMETERY OR CREMATORY Secret West		22d. LOCATION (City, town, or county) (State) Bushwood Md	
23. FUNERAL DIRECTOR'S SIGNATURE R.G. Matherly		ADDRESS 131-11th St. S.E.	
24a. REC'D BY REGISTRAR DATE JAN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01045

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1021

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS Brockridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Daniel Middle Powell Last			4. DATE OF DEATH Month January Day 6 Year 19 59		
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-23	9. AGE (in years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Powell		
14. MOTHER'S MAIDEN NAME Estelle Thomas			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 218-12-0519			17. INFORMANT Lee Powell; 602 9th St., Laurel, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured skull and crushed chest DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with a school bus.		
20c. TIME OF INJURY Month, Day, Year 1-6-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Bacontown		20g. (County) Ann Arundel		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 1-6-59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-9-59		22c. NAME OF CEMETERY OR CREMATORY Bacon Chapel	
22d. LOCATION (City, town, or county) Laurel, Md		22e. (State) Md		22f. (City, town, or county) Laurel, Md	
23. FUNERAL DIRECTOR'S SIGNATURE R. Selby, 1200 Snowden Place, Laurel, Md			24a. REC'D BY REGISTRAR DATE JAN 12 '59		
24b. REGISTRAR'S SIGNATURE Arthur L. Frank			24c. REGISTRAR'S SIGNATURE Arthur L. Frank		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STATE
DEATH CERT

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report	
Signature of Physician		Signature of Nurse		Signature of Hospital	
Signature of Family		Signature of Friends		Signature of Community	
Signature of Church		Signature of School		Signature of Government	
Signature of Other		Signature of Other		Signature of Other	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01048

1023

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5601 57th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Louise Last Pumphrey		4. DATE OF DEATH Month January Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 48 Days 10 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Columbus Pumphrey		14. MOTHER'S MAIDEN NAME Charlotte Condie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. ---	
17. INFORMANT LeRoy Pumphrey-Riverdale, Maryland.		17. ADDRESS 5601 57th Avenue,	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 525x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO (c) Fibrosis, pulmonary		INTERVAL BETWEEN ONSET AND DEATH 48 hours 2 mos 4 to 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/14 , 19 54 , to 1/21 , 19 59 , that I last saw the deceased alive on 1/21/59 , 19 59 , and that death occurred at 6 p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1746 K St., N.W., Washington, D. C. DATE SIGNED Jan. 21, "59"			
ACTUAL SIGNATURE John D. Foley M.D.		PHYSICIAN'S NAME (Type) John D. Foley, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/24/59	
22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		24a. REC'D BY REGISTRAR FEB 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hinn			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Rev. 10-1-1918

Form with multiple sections for recording death information, including fields for name, age, sex, date of death, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.

Name of Deceased		Age		Sex	
Date of Death		Time of Death		Place of Death	
Cause of Death		Disease		Occupation	
Signature of Physician		Signature of Registrar		Signature of Witness	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01049

1024

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>		c. LENGTH OF STAY IN 1b <u>2 mo. 2 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>13838 - 34th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Maggie</u> First <u>B.</u> Middle <u>Rankin</u> Last		4. DATE OF DEATH <u>Jan. 5</u> Month <u>19</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/70</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry M. Clay</u>		14. MOTHER'S MAIDEN NAME <u>Annie Archibald</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>C.L. Rankin</u>		Address <u>3838 - 34th St. N.W. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Branchio pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis Ht. dis.</u> DUE TO (c) <u>40 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 3</u> , 19 <u>59</u> , to <u>Jan 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 5</u> , 19 <u>59</u> , and that death occurred at <u>9:03 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. A. Holbrook</u> M.D.		ADDRESS (Street, city or town, state) <u>4500 College Ave., College Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wm. A. Holbrook, Md.</u>		DATE SIGNED <u>1/5/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>1-8-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Switzland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		ADDRESS <u>5801 Cleveland Ave</u>	
24a. REC'D BY REGISTRAR <u>JAN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>John E. Kinn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

1934

Baltimore

1934

1934

1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

Item 18 Film 238 2-13-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01047

1022

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 13 Hrs 35 Min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville, 15 d. STREET ADDRESS 3406 Tulane Dr., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rice		4. DATE OF DEATH Month Day Year January 23 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 59
9. AGE (In years last birthday) yrs. 13		10. IF UNDER 1 YEAR Months Days Hours Min. 13 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Sidney Hoffman		14. MOTHER'S MAIDEN NAME Alma Hoffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resorption Atelectasis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET, AND DEATH 14 hrs.			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 23, 1959 , to January 23 1959 , that I last saw the deceased alive on January 23, 1959 , and that death occurred at 8:15P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Hyattsville Md 1/25/59			
ACTUAL SIGNATURE Gordon W Kelley M.D. 6124-41st Ave PHYSICIAN'S NAME (Type) Dr. Gordon Kelley Hyattsville Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 1/27/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr. ADDRESS Administrator.		24a. REC'D BY REGISTRAR DATE FEB 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

2077323XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1025

CERTIFICATE OF DEATH

01050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 12209 Jamison Street	
3. NAME OF DECEASED (Type or print) First William Middle M. Last Richardson		4. DATE OF DEATH Month Jan. Day 7 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1887
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN, RET.		10b. KIND OF BUSINESS OR INDUSTRY WASH. NAVY YARD	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK RICHARDSON		14. MOTHER'S MAIDEN NAME MARY CARROLL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MARIAN MILLER		Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Sub arad. Hemorrh. 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arterioscler. of disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 7 , 19 59 , to Jan 7 , 19 59 , that I last saw the deceased alive on Jan 7 , 19 59 , and that death occurred at 730P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Peter Duus		M.D. 6124 central Ave.	
PHYSICIAN'S NAME (Type) Dr Peter Duus		Capitol Heights, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home		24a. REC'D BY REGISTRAR DATE JAN 12 '59	
ADDRESS 2nd Mt. Rainier, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

CERTIFICATE OF DEATH

033

5-24-1918

Name of deceased		John A. Smith	
Sex		Male	
Age		45	
Date of birth		Jan 15, 1873	
Place of birth		Maryland	
Usual residence		Baltimore, Md.	
Cause of death		Heart disease	
Immediate cause		Myocardial infarction	
Intermediate cause		Hypertension	
Underlying cause		Atherosclerosis	
Duration of illness		2 weeks	
Place of death		Home	
Time of death		10:30 AM	
Day of week		Monday	
Month		May	
Year		1918	
Signature of physician		J. H. Jones	
Signature of registrar		W. B. Smith	
Signature of informant		J. A. Smith	
Signature of witness		J. B. Smith	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND
MAY 24 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01051

970

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7417 84th Blace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Alvin Rochelle</u>		4. DATE OF DEATH Month Day Year <u>Jan 21 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1874</u>
9. AGE (In years last birthday) <u>85 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cotton Mill Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Fendall Rochelle</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES Christian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>240-01-7841</u>	
17. INFORMANT <u>Norman Rochelle</u>		Address <u>7417-84th Place Hyattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19____, to <u>Jan</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19 Jan</u> , 19 <u>59</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7315 Landover Rd Hyattsville, Md 21 Jan 1959</u>			
ACTUAL SIGNATURE <u>Thomas M. Hutchins</u>		M.D. <u>Hyattsville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas M Hutchins</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>1/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Durham</u>		22d. LOCATION (City, town, or county) (State) <u>North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 22 59</u>	
ADDRESS <u>Hyattsville Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

578

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. DATE OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. CAUSE OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESS</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>		<p>15. SIGNATURE OF REGISTRAR</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF PHYSICIAN</p>		<p>19. SIGNATURE OF CORONER</p>		<p>20. SIGNATURE OF REGISTRAR</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF WITNESS</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF CORONER</p>		<p>25. SIGNATURE OF REGISTRAR</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF WITNESS</p>		<p>28. SIGNATURE OF PHYSICIAN</p>		<p>29. SIGNATURE OF CORONER</p>		<p>30. SIGNATURE OF REGISTRAR</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF WITNESS</p>		<p>33. SIGNATURE OF PHYSICIAN</p>		<p>34. SIGNATURE OF CORONER</p>		<p>35. SIGNATURE OF REGISTRAR</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF WITNESS</p>		<p>38. SIGNATURE OF PHYSICIAN</p>		<p>39. SIGNATURE OF CORONER</p>		<p>40. SIGNATURE OF REGISTRAR</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF WITNESS</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF CORONER</p>		<p>45. SIGNATURE OF REGISTRAR</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF WITNESS</p>		<p>48. SIGNATURE OF PHYSICIAN</p>		<p>49. SIGNATURE OF CORONER</p>		<p>50. SIGNATURE OF REGISTRAR</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF WITNESS</p>		<p>53. SIGNATURE OF PHYSICIAN</p>		<p>54. SIGNATURE OF CORONER</p>		<p>55. SIGNATURE OF REGISTRAR</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF WITNESS</p>		<p>58. SIGNATURE OF PHYSICIAN</p>		<p>59. SIGNATURE OF CORONER</p>		<p>60. SIGNATURE OF REGISTRAR</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESS</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF CORONER</p>		<p>65. SIGNATURE OF REGISTRAR</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF WITNESS</p>		<p>68. SIGNATURE OF PHYSICIAN</p>		<p>69. SIGNATURE OF CORONER</p>		<p>70. SIGNATURE OF REGISTRAR</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF WITNESS</p>		<p>73. SIGNATURE OF PHYSICIAN</p>		<p>74. SIGNATURE OF CORONER</p>		<p>75. SIGNATURE OF REGISTRAR</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF WITNESS</p>		<p>78. SIGNATURE OF PHYSICIAN</p>		<p>79. SIGNATURE OF CORONER</p>		<p>80. SIGNATURE OF REGISTRAR</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF WITNESS</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF CORONER</p>		<p>85. SIGNATURE OF REGISTRAR</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF WITNESS</p>		<p>88. SIGNATURE OF PHYSICIAN</p>		<p>89. SIGNATURE OF CORONER</p>		<p>90. SIGNATURE OF REGISTRAR</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF WITNESS</p>		<p>93. SIGNATURE OF PHYSICIAN</p>		<p>94. SIGNATURE OF CORONER</p>		<p>95. SIGNATURE OF REGISTRAR</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF WITNESS</p>		<p>98. SIGNATURE OF PHYSICIAN</p>		<p>99. SIGNATURE OF CORONER</p>		<p>100. SIGNATURE OF REGISTRAR</p>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John J. Jones, Jr.		35		Male	
Residence		Occupation		Cause of Death	
1234 Main St., Baltimore, Md.		Engineer		Heart Disease	
Date of Death		Time of Death		Place of Death	
Jan. 1, 1933		10:15 A.M.		Home	
Physician		Medical Examiner		Signature	
Dr. J. H. Smith		J. A. A.		[Signature]	
Hospital		Burial Place		Remarks	
St. Mary's Hospital		Catholic Cemetery		No autopsy performed	
Manner of Death		Disease		Organ	
Natural		Coronary Atherosclerosis		Heart	
Suicide		Homicide		Accident	
Other		Other		Other	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01053

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mount Rainier</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4308 Russell Ave.</u>		d. STREET ADDRESS <u>14308 Russell Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Philip Joseph Bryan</u>		4. DATE OF DEATH <u>Jan - 4</u> 1959.	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Joseph Bryan</u>		14. MOTHER'S MAIDEN NAME <u>Lillian May Hutton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>6515-8 on file</u>	
17. INFORMANT <u>James G. Gullis Hyattsville, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease.</u> (c) <u>Carthorascular renal disease.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-4-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan. 7/59</u>		22b. DATE THEREOF <u>mt. Olivet</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington D.C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u> ADDRESS <u>mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 9 59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Robert S. Thoms</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon properly. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01054

1027

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Pearl A Ryon		4. DATE OF DEATH January 22 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/09
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 49 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward B. Moore		12. CITIZEN OF WHAT COUNTRY? United States	
14. MOTHER'S MAIDEN NAME Elizabeth D. Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Howard Ryon Husband Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO INTESTINAL HEMORRHAGE DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESOPHAGEAL VARICOSES DUE TO 6 mos (c) CIRRHOSIS OF LIVER DUE TO 5 yrs		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 52 to JAN 22 19 59 , that I last saw the deceased alive on JAN 22 19 59 , and that death occurred at 6 40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Bureau M.D.		ADDRESS (Street, city or town, state) 3503 Penny St DATE SIGNED 1/22/59	
PHYSICIAN'S NAME (Type) NORMAN DONAT BUREAU		MT Rainier Md	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/26/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John Lee Jones		ADDRESS 300-44th E. Wash DC	
24a. REC'D BY REGISTRAR JAN 26 59		24b. REGISTRAR'S SIGNATURE Carlton S. Kraw	

971

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN lb 2 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4400 Madison St		d. STREET ADDRESS 4400 Madison St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Elsie Sanders		4. DATE OF DEATH Month Day Year Jan 21, 19 59-	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Boles		14. MOTHER'S MAIDEN NAME Mary Jane Iams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 168 09 6818 B	
17. INFORMANT Willa Cotterman		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix - Metastasis to 171X DUE TO Involvement of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 19 58 to Jan 21, 19 59 , that I last saw the deceased alive on Jan 20, 19 59 , and that death occurred at 12:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5432 Queens Chapel Rd 1/22/59 ACTUAL SIGNATURE Ronald S Fleischer M.D. PHYSICIAN'S NAME (Type) RONALD S FLEISCHER Hyattsville			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 1/23/59		22b. DATE THEREOF 1/23/59	
22c. NAME OF CEMETERY OR CREMATORY Follansbee		22d. LOCATION (City, town, or county) (State) West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR Jan 26 59	
ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE Robert S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CLERK</p>	
<p>15. SIGNATURE OF REGISTRAR</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF SHERIFF</p>		<p>18. SIGNATURE OF CORONER</p>	
<p>19. SIGNATURE OF JURY</p>		<p>20. SIGNATURE OF COURT</p>	
<p>21. SIGNATURE OF STATE</p>		<p>22. SIGNATURE OF COUNTY</p>	
<p>23. SIGNATURE OF CITY</p>		<p>24. SIGNATURE OF TOWN</p>	
<p>25. SIGNATURE OF VILLAGE</p>		<p>26. SIGNATURE OF PLANTATION</p>	
<p>27. SIGNATURE OF PARISH</p>		<p>28. SIGNATURE OF CHURCH</p>	
<p>29. SIGNATURE OF CONGREGATION</p>		<p>30. SIGNATURE OF SYNAGOGUE</p>	
<p>31. SIGNATURE OF MOSQUE</p>		<p>32. SIGNATURE OF TEMPLE</p>	
<p>33. SIGNATURE OF DORM</p>		<p>34. SIGNATURE OF HOUSE</p>	
<p>35. SIGNATURE OF FARM</p>		<p>36. SIGNATURE OF MANOR</p>	
<p>37. SIGNATURE OF ESTATE</p>		<p>38. SIGNATURE OF LAND</p>	
<p>39. SIGNATURE OF TENEMENT</p>		<p>40. SIGNATURE OF HOUSEHOLD</p>	
<p>41. SIGNATURE OF FAMILY</p>		<p>42. SIGNATURE OF SOCIETY</p>	
<p>43. SIGNATURE OF ORDER</p>		<p>44. SIGNATURE OF COMPANY</p>	
<p>45. SIGNATURE OF CORPORATION</p>		<p>46. SIGNATURE OF FRANCHISE</p>	
<p>47. SIGNATURE OF CONFRATERNITY</p>		<p>48. SIGNATURE OF GUILD</p>	
<p>49. SIGNATURE OF LODGE</p>		<p>50. SIGNATURE OF ORDER</p>	
<p>51. SIGNATURE OF SOCIETY</p>		<p>52. SIGNATURE OF COMPANY</p>	
<p>53. SIGNATURE OF CORPORATION</p>		<p>54. SIGNATURE OF FRANCHISE</p>	
<p>55. SIGNATURE OF CONFRATERNITY</p>		<p>56. SIGNATURE OF GUILD</p>	
<p>57. SIGNATURE OF LODGE</p>		<p>58. SIGNATURE OF ORDER</p>	
<p>59. SIGNATURE OF SOCIETY</p>		<p>60. SIGNATURE OF COMPANY</p>	
<p>61. SIGNATURE OF CORPORATION</p>		<p>62. SIGNATURE OF FRANCHISE</p>	
<p>63. SIGNATURE OF CONFRATERNITY</p>		<p>64. SIGNATURE OF GUILD</p>	
<p>65. SIGNATURE OF LODGE</p>		<p>66. SIGNATURE OF ORDER</p>	
<p>67. SIGNATURE OF SOCIETY</p>		<p>68. SIGNATURE OF COMPANY</p>	
<p>69. SIGNATURE OF CORPORATION</p>		<p>70. SIGNATURE OF FRANCHISE</p>	
<p>71. SIGNATURE OF CONFRATERNITY</p>		<p>72. SIGNATURE OF GUILD</p>	
<p>73. SIGNATURE OF LODGE</p>		<p>74. SIGNATURE OF ORDER</p>	
<p>75. SIGNATURE OF SOCIETY</p>		<p>76. SIGNATURE OF COMPANY</p>	
<p>77. SIGNATURE OF CORPORATION</p>		<p>78. SIGNATURE OF FRANCHISE</p>	
<p>79. SIGNATURE OF CONFRATERNITY</p>		<p>80. SIGNATURE OF GUILD</p>	
<p>81. SIGNATURE OF LODGE</p>		<p>82. SIGNATURE OF ORDER</p>	
<p>83. SIGNATURE OF SOCIETY</p>		<p>84. SIGNATURE OF COMPANY</p>	
<p>85. SIGNATURE OF CORPORATION</p>		<p>86. SIGNATURE OF FRANCHISE</p>	
<p>87. SIGNATURE OF CONFRATERNITY</p>		<p>88. SIGNATURE OF GUILD</p>	
<p>89. SIGNATURE OF LODGE</p>		<p>90. SIGNATURE OF ORDER</p>	
<p>91. SIGNATURE OF SOCIETY</p>		<p>92. SIGNATURE OF COMPANY</p>	
<p>93. SIGNATURE OF CORPORATION</p>		<p>94. SIGNATURE OF FRANCHISE</p>	
<p>95. SIGNATURE OF CONFRATERNITY</p>		<p>96. SIGNATURE OF GUILD</p>	
<p>97. SIGNATURE OF LODGE</p>		<p>98. SIGNATURE OF ORDER</p>	
<p>99. SIGNATURE OF SOCIETY</p>		<p>100. SIGNATURE OF COMPANY</p>	

1065

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Pr. Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Upper Marlboro</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Upper Marlboro, Ind</i>	
c. LENGTH OF STAY IN 1b <i>Life</i>		d. STREET ADDRESS <i>1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY Beale SASSCER</i>		4. DATE OF DEATH <i>Jan 4, 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>28 Apr 79</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hom</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Buchanan Beale</i>		14. MOTHER'S MAIDEN NAME <i>Helen Margaretta Hill</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Dr. R. B. Sasscer, M.D.</i>		Address <i>Upper Marlboro, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic pneumonia</i> DUE TO <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congestive Heart Failure</i> DUE TO <i>36 hrs</i> (c) <i>Arteriosclerotic C & V disease</i> <i>30 hrs</i> INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>19 hrs</i> , 1958, to <i>4 Jan</i> , 1959, that I last saw the deceased alive on <i>4 Jan</i> , 1959, and that death occurred at <i>644 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R B Sasscer</i>		DATE SIGNED <i>Upper Marlboro Ind 4 Jan 59</i>	
PHYSICIAN'S NAME (Type) <i>R. B. Sasscer, M.D.</i>		Upper Marlboro, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/6/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Trinity Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Upper Marlboro Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ritchie Bros. Funeral Home-Marlboro, Md.</i>		24a. REC'D BY REGISTRAR <i>JAN 12 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1028

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u>		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cheverly</u>		<u>D.O.A.</u>		TOWN <u>East Riverdale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>Prince George General</u>				<u>5710 64th Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Melvin</u> (Middle) <u>Leslie</u> (Last) <u>Shneider</u>				(Month) <u>1</u> (Day) <u>16</u> (Year) <u>19 59</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Oct. 25, 1895</u>	<u>63</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Printer retired</u>					<u>Maryland</u>		<u>U.S.A</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry M. Schneider</u>				<u>Anna Eichhorn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>East Riverdale Md</u> <u>Wife</u> <u>Ethel N Schneider, 5710 64th Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
150X IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-15-59</u> , 19 <u>59</u> , to <u>1-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-15-59</u> , 19 <u>59</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>John P. Cunn</u>				<u>Hyndman, Pennsylvania</u>		<u>1-16-59</u>	
23. BURIAL-CREATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>1/17/59</u>		<u>--</u>		<u>Hyndman, Pennsylvania</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>JAN 19 '59</u>		<u>Carlton S. House</u>		<u>The S.H. Hines Co.</u>		<u>2901 14th St. NW</u> <u>Washington, D.C.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1928

State of Maryland

1. DECEASED'S NAME (In full, as given)

2. SEX (Male or Female)

3. AGE (In years, months, and days)

4. DATE OF BIRTH (In full)

5. PLACE OF BIRTH (In full)

6. OCCUPATION (In full)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. COLOR (In full)

9. RELIGION (In full)

10. EDUCATION (In full)

11. PLACE OF DEATH (In full)

12. DATE OF DEATH (In full)

13. TIME OF DEATH (In full)

14. CAUSE OF DEATH (In full)

15. MANNER OF DEATH (In full)

16. SIGNATURE OF PHYSICIAN (In full)

17. SIGNATURE OF CORONER (In full)

18. SIGNATURE OF WITNESS (In full)

19. SIGNATURE OF DECEASED (In full)

20. SIGNATURE OF NEXT OF KIN (In full)

21. SIGNATURE OF CLERGYMAN (In full)

22. SIGNATURE OF BURIAL OFFICIAL (In full)

23. SIGNATURE OF INTERVIEWER (In full)

24. SIGNATURE OF REGISTRAR (In full)

25. SIGNATURE OF CLERK (In full)

26. SIGNATURE OF ASSISTANT CLERK (In full)

27. SIGNATURE OF CHIEF CLERK (In full)

28. SIGNATURE OF DEPUTY CHIEF CLERK (In full)

29. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK (In full)

30. SIGNATURE OF CLERK (In full)

1. DECEASED'S NAME (In full, as given)

2. SEX (Male or Female)

3. AGE (In years, months, and days)

4. DATE OF BIRTH (In full)

5. PLACE OF BIRTH (In full)

6. OCCUPATION (In full)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. COLOR (In full)

9. RELIGION (In full)

10. EDUCATION (In full)

11. PLACE OF DEATH (In full)

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6. OCCUPATION (In full)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

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3. AGE (In years, months, and days)

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5. PLACE OF BIRTH (In full)

6. OCCUPATION (In full)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

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29. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK (In full)

30. SIGNATURE OF CLERK (In full)

1. DECEASED'S NAME (In full, as given)

2. SEX (Male or Female)

3. AGE (In years, months, and days)

4. DATE OF BIRTH (In full)

5. PLACE OF BIRTH (In full)

6. OCCUPATION (In full)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. COLOR (In full)

9. RELIGION (In full)

10. EDUCATION (In full)

11. PLACE OF DEATH (In full)

12. DATE OF DEATH (In full)

13. TIME OF DEATH (In full)

14. CAUSE OF DEATH (In full)

15. MANNER OF DEATH (In full)

16. SIGNATURE OF PHYSICIAN (In full)

17. SIGNATURE OF CORONER (In full)

18. SIGNATURE OF WITNESS (In full)

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29. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK (In full)

30. SIGNATURE OF CLERK (In full)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 1066
 CERTIFICATE OF DEATH

01058

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Maryland Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6527 D St.</u>		d. STREET ADDRESS <u>6527 D St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MINNIE</u> First Middle Last		4. DATE OF DEATH <u>JAN 7 1959</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Balt md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY SEITZ</u>		14. MOTHER'S MAIDEN NAME <u>PAULINE BODTKA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>FLORENCE LINDSEY</u>		Address <u>206 72nd Pl.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with generalized arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>48</u> , to <u>Jan 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>	
PHYSICIAN'S NAME (Type) <u>W.M. BRAININ</u>		DATE SIGNED <u>1/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 12 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

CERTIFICATE OF DEATH

USA

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF NURSE

NAME OF PHYSICIAN

NAME OF SURGEON

NAME OF DENTIST

NAME OF OPTICIAN

NAME OF PODIATRIST

NAME OF VETERINARIAN

NAME OF PHARMACEUTICIST

NAME OF LABORATORY

NAME OF RADIOLOGIST

NAME OF PATHOLOGIST

NAME OF HISTOLOGIST

NAME OF CYTOLOGIST

NAME OF MICROSCOPIC

NAME OF RADIOLOGICAL

NAME OF PHYSIOLOGICAL

NAME OF ANATOMICAL

NAME OF PHYSIOLOGICAL

NAME OF ANATOMICAL

NAME OF PHYSIOLOGICAL

NAME OF ANATOMICAL

NAME OF PHYSIOLOGICAL

NAME OF ANATOMICAL

NAME OF PHYSIOLOGICAL

NAME OF ANATOMICAL

CERTIFICATE OF DEATH

Reg. Dist. No.

1067

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE DISTRICT OF COLUMBIA D. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB BASE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, ANDREWS				d. STREET ADDRESS 639 CONDON TERR. 47X-3			
3. NAME OF DECEASED (Type or print) First NEWBORN Middle SENTIPAL Last				4. DATE OF DEATH Month JANUARY Day 19 Year 1959			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 19, 1959	
9. AGE (In years last birthday) - yrs.		IF UNDER 1 YEAR Months - Days - Hours 11 Min. 34		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EMIL J. SENTIPAL		14. MOTHER'S MAIDEN NAME MASIE M HENSLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. NA		17. INFORMANT Address MOTHER- MRS EMIL SENTIPAL- see #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Failure (c) Multiple Congenital Anomalies							INTERVAL BETWEEN ONSET AND DEATH None 30 min 11 hrs 54 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 19, 1959 , to JAN 19, 1959 , that I last saw the deceased alive on 19 Jan , 19 59 , and that death occurred at 10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 19 JAN 59 DATE SIGNED ACTUAL SIGNATURE Vincent P. Ringrose Jr. M.D. USAF HOSPITAL, ANDREWS PHYSICIAN'S NAME (Type) VINCENT P. RINGROSE JR. CAPT USAF(MC) ANDREWS AFB WASH 25 D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 20 JAN 59		22c. NAME OF CEMETERY OR CREMATORY D. C. MORGUE		22d. LOCATION (City, town, or county) (State) DISTRICT OF COLUMBIA	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE JAN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

2050365XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1068

CERTIFICATE OF DEATH

01059

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Pr. Geo's. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland.		c. LENGTH OF STAY IN 1b 12 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102- Swann Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lena Middle Maud Last Seymour		4. DATE OF DEATH Month Jan. Day 21st. Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16th 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roy S. Curry		14. MOTHER'S MAIDEN NAME Jennie Hunter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Vernon M. Seymour		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral Hemorrhage DUE TO (c) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 5 hrs 2 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 9 , 19 58 , to Jan 21 , 19 59 , that I last saw the deceased alive on Jan 14 , 19 59 , and that death occurred at 4:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, and state) 6001- 35th. Ave. Hyattsville, Md. DATE SIGNED Jan. 21-59 ACTUAL SIGNATURE W H Clements M.D. PHYSICIAN'S NAME (Type) William H. Clements 6001- 35th. Ave. Hyattsville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		24a. REC'D BY REGISTRAR DATE JAN 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Knead			

CERTIFICATE OF DEATH

1888

NAME OF DECEASED JAMES COOPER		SEX Male		AGE 35	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk		COLOR White	
DATE OF DEATH Jan 15 1888		TIME OF DEATH 10:30 A.M.		PLACE OF DEATH Home	
CAUSE OF DEATH Apoplexy		DISEASE None		PRESENT ILLNESS None	
MEDICAL ATTENDANT J. H. Smith		BURIAL PLACE St. Paul's Church		DATE OF BURIAL Jan 16 1888	
SIGNATURE OF MEDICAL ATTENDANT J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith		DATE Jan 16 1888	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01060

1029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale d. STREET ADDRESS 02X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clinton E. Shaffer		4. DATE OF DEATH Month January Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/76
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Howard Co. Md		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Emanuel Shaffer		14. MOTHER'S MAIDEN NAME Louisa Grimes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Harry Gerwig Neice		Address Ellicott City Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma prostate c multiple metastases DUE TO (c) 8 mos INTERVAL BETWEEN ONSET AND DEATH 1 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 1958 , to 18 Jan 1959 , that I last saw the deceased alive on January 18 , 1959 , and that death occurred at 2:55 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Robert Sasscer		ADDRESS (Street, city or town, state) Upper Marlboro Md DATE SIGNED 1-19-59	
PHYSICIAN'S NAME (Type) Dr. Robert Sasscer M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-1959	
22c. NAME OF CEMETERY OR CREMATORY Western		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham		ADDRESS Ellicott City, Md	
24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kinner	

CERTIFICATE OF DEATH

STATE OF NEW YORK

1900

NAME OF DECEASED

AGE

SEX

DATE

PLACE

TIME

CAUSE

MANNER

PLACE

TIME

CAUSE

MANNER

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972 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON, D.C. b. COUNTY WASHINGTON, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b 1 YEAR			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR				d. STREET ADDRESS 2227 20th STREET, N.W.			
3. NAME OF DECEASED (Type or print) HELEN A. SHEHAN				4. DATE OF DEATH 1-5-1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-21-77	
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL WORK		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL WORK				10b. KIND OF BUSINESS OR INDUSTRY SOUTHERN RAILROAD			
13. FATHER'S NAME MICHAEL P. SHEHAN				14. MOTHER'S MAIDEN NAME MARY E. SHEHAN (NO RELATION)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Sister M. Jean Thorne-Carroll Manor	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Acute Congestive Heart Failure DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Glomerular Nephritis				INTERVAL BETWEEN ONSET AND DEATH 15 days 20 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 1949 to Jan 5, 1959 , that I last saw the deceased alive on 5 Jan 1959 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis T. Coleman				DATE SIGNED 5 Jan 59			
PHYSICIAN'S NAME (Type) Francis T. Coleman				ADDRESS 5315-16th St N.W. D.C.			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
burial		1/7/59		Mt. Olivet Cemetery		Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.,				24. REC'D BY REGISTRAR JAN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician	
John Doe		Male		45		Jan 1, 1900		New York City		123 Main St		Heart Disease		Jan 15, 1945		10:00 AM		Home		J. A. Smith		D. E. Jones	
Occupation		Marital Status		Color		Height		Weight		Education		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice	
Teacher		Married		White		5' 10"		175 lbs		High School		None		Jan 10, 1945		None		None		None		None	
Date of Death		Time of Death		Place of Death		Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist		Signature of Surgeon		Signature of Dentist		Signature of Pharmacist	
Jan 15, 1945		10:00 AM		Home		J. A. Smith		D. E. Jones		F. G. Brown		H. I. Green		K. L. White		M. N. Black		O. P. Gray		Q. R. Blue		S. T. Red	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this 15th day of January, 1945.

 Registrar of Deaths

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1030

CERTIFICATE OF DEATH

Reg. Dist. No.

01062

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write Beltsville Md)				c. CITY OR TOWN (If outside corporate limits, write Beltsville, Md.)			
c. LENGTH OF STAY IN IB 14 years				d. STREET ADDRESS 11815 Old Gunpowder Rd			
d. NAME OF HOSPITAL (If not in hospital, give street address) 11815 Old Gunpowder Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Norval Middle Harrison Last Spicknall				4. DATE OF DEATH Month Jan Day 21 , Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 14, 1882		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Charles Spicknall				14. MOTHER'S MAIDEN NAME Louisa Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Hester Louisa Spicknall Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 4-1 , 19 59 to 1-21 , 19 59 , that I last saw the deceased alive on 1-20 , 19 59 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314- GALLATIN ST. 1-21-59 DATE SIGNED ACTUAL SIGNATURE AARON DEITZ, M.D. PHYSICIAN'S NAME (Type) HYATTSVILLE MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/23/59		22c. NAME OF CEMETERY OR George Washington	
22d. LOCATION (City, town, or county) Hyattsville, Md.				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE JAN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MINISTRY OF HEALTH - SINGAPORE
CERTIFICATE OF DEATH

1. Name of the deceased
2. Age
3. Sex
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of the medical officer
9. Signature of the registrar
10. Signature of the informant

1. Name of the deceased
2. Age
3. Sex
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of the medical officer
9. Signature of the registrar
10. Signature of the informant

1. Name of the deceased
2. Age
3. Sex
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of the medical officer
9. Signature of the registrar
10. Signature of the informant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01063

Reg. Dist. No.

1069

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>SPRINGFIELD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>USAF HOSPITAL</u>				c. LENGTH OF STAY IN 1b <u>83X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANDREWS AFBASE</u>				d. STREET ADDRESS <u>6703 FRONT ROYAL Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>W</u> Last <u>STEINKAMP</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>5</u> Year <u>1959</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 21, 1917</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PILOT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US AIR FORCE</u>		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CARL W STEINKAMP</u>				14. MOTHER'S MAIDEN NAME <u>ELVIE LEE FISHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>408-12-3247</u>		17. INFORMANT Address <u>Wife - MRS. STEINKAMP - SAME AS #2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>251X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anesthesia + surgery</u> DUE TO (c) <u>Thyroid adenoma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Dec 18</u> , 19 <u>58</u> , to <u>5/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5 Jan</u> , 19 <u>59</u> , and that death occurred at <u>1500</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>STANS9</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Edward H. Vas Nues</u> M.D. <u>USAF HOSPITAL, ANDREWS</u>							
PHYSICIAN'S NAME (Type) <u>EDWARD H. VAS NUES CAPT USAF (MD)</u> <u>ANDREWS AFB WASH. 25-D.C.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JAN 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>MEMPHIS TENNESSEE</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME, 816 H ST. N.E., WASH, DC.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrash</u>	

MEDICAL CERTIFICATION

2

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CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. DATE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF FUNERAL HOME</p>		<p>16. SIGNATURE OF BURIAL PLACE</p>	
<p>17. SIGNATURE OF VENDOR</p>		<p>18. SIGNATURE OF OTHER</p>	
<p>19. SIGNATURE OF OTHER</p>		<p>20. SIGNATURE OF OTHER</p>	
<p>21. SIGNATURE OF OTHER</p>		<p>22. SIGNATURE OF OTHER</p>	
<p>23. SIGNATURE OF OTHER</p>		<p>24. SIGNATURE OF OTHER</p>	
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<p>81. SIGNATURE OF OTHER</p>		<p>82. SIGNATURE OF OTHER</p>	
<p>83. SIGNATURE OF OTHER</p>		<p>84. SIGNATURE OF OTHER</p>	
<p>85. SIGNATURE OF OTHER</p>		<p>86. SIGNATURE OF OTHER</p>	
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<p>89. SIGNATURE OF OTHER</p>		<p>90. SIGNATURE OF OTHER</p>	
<p>91. SIGNATURE OF OTHER</p>		<p>92. SIGNATURE OF OTHER</p>	
<p>93. SIGNATURE OF OTHER</p>		<p>94. SIGNATURE OF OTHER</p>	
<p>95. SIGNATURE OF OTHER</p>		<p>96. SIGNATURE OF OTHER</p>	
<p>97. SIGNATURE OF OTHER</p>		<p>98. SIGNATURE OF OTHER</p>	
<p>99. SIGNATURE OF OTHER</p>		<p>100. SIGNATURE OF OTHER</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01064

1031

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital				d. STREET ADDRESS Contee Sand and Gravel Co			
3. NAME OF DECEASED (Type or print) Ludie First Stringfield Last				4. DATE OF DEATH Month Jan Day 2 Year 1959			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-98	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 2 Days 2		IF UNDER 24 HRS. Hours 2 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman				10b. KIND OF BUSINESS OR INDUSTRY Sand and Gravel		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Eddie Stringfield				14. MOTHER'S MAIDEN NAME Hannah Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 243-01-4659		17. INFORMANT Address Lonnie Stringfield; Rt. 1 Box 180, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9323 Exposure to cold DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lying out in weather DUE TO (c) Reason unknown</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exposure to cold					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1-2- 19 59 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) place of Employment		20f. (City or town) (County) (State) Laurel Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED January 2, 1959							
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-8-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Mt Zion Church		22d. LOCATION (City, town, or county) (State) Laurel Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington				ADDRESS 467 N. St. N.W.		24a. REC'D BY REGISTRAR DATE JAN 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Book or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG239 2-24-59 et

01065

976

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT RAINIER		c. LENGTH OF STAY IN 1b 5 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS 13105 Arundel Road	
3. NAME OF DECEASED (Type or print) CLARA K STROUS		4. DATE OF DEATH Month 1 - Day 14 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 4-1-1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Callothsburg Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Krish		14. MOTHER'S MAIDEN NAME Rosie Brint	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Bert P Leda		Address Mt Rainier md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X DUE TO pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sen. Arteriosclerosis; rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 11, 1959 to Jan 14, 1959 that I last saw the deceased alive on Jan 13, 1959 and that death occurred at 12 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Darin M. Grassgreen M.D. 3101 Arundel Rd.			
PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN, M.D. Mt. Rainier Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-16-59	
22c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		22d. LOCATION (City, town, or county) (State) Ashland Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers G		ADDRESS 1400 Chapin St Md	
24a. REC'D BY REGISTRAR JAN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

WILLIAM BARNHART
DECEASED
BARNHART, MISSOURI

MISSOURI STATE DEPARTMENT OF HEALTH - BARNHART 18

CERTIFICATE OF DEATH

01066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT HEIGHTS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, ANDREWS		e. STREET ADDRESS 7611 ATWOOD ST.	
3. NAME OF DECEASED (Type or print) First KENNETH Middle WAYNE Last TAYLOR		4. DATE OF DEATH Month JANUARY Day 21 Year 1959	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 21, 1959
9. AGE (In years last birthday) — yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours 17 Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT W. TAYLOR		14. MOTHER'S MAIDEN NAME CAROL A. CAMARIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. NA	
17. INFORMANT FATHER-ROBERT W. TAYLOR-JEC #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYALIN MEMBRANE DISEASE DUE TO 773.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 17 HRS.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 21 JAN , 19 59 , to 21 JAN , 19 59 , that I last saw the deceased alive on 21 JAN , 19 59 , and that death occurred at 4:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 21 JAN 59 DATE SIGNED			
ACTUAL SIGNATURE Douglas E. Pierce M.D. USAF HOSPITAL, ANDREWS			
PHYSICIAN'S NAME (Type) DOUGLAS E. PIERCE CAPT USAF (MC) ANDREWS AF BASE, WASH 25 D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 26 1959	22c. NAME OF CEMETERY OR CREMATORY Columbia National	22d. LOCATION (City, town, or county) (State) Columbia Va.
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home		24a. REC'D BY REGISTRAR DAWN 2 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knecht

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
11. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i>		12. SIGNATURE OF CLERK <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>	
27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF DECEASED <i>John Doe</i>	
35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>	
39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF DECEASED <i>John Doe</i>	
47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>	
59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>	
63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>	
75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF DECEASED <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>	
83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>	
87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF DECEASED <i>John Doe</i>	
95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>	
99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G237 1-14-59 et

01067

1032

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Betty First E. Middle Tayman Last				4. DATE OF DEATH Jan 3 Month Jan 3 Day 39 Year 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1901	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Arkansas	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George C Ross				14. MOTHER'S MAIDEN NAME Ada M. Henry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Ada M. Ross Address Cheverly, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, cervix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 171X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3414 Gallatin St. DATE SIGNED _____							
ACTUAL SIGNATURE A. Dietz				PHYSICIAN'S NAME (Type) Dr. Aaron Dietz			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/6/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR JAN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hous	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1032

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1900</u></p>	
<p>5. Place of birth: <u>St. Louis, Mo.</u></p>		<p>6. Date of death: <u>Dec 10, 1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>Dec 15, 1945</u></p>		<p>12. Place of registration: <u>Baltimore, Md.</u></p>	

RECEIVED
BALTIMORE, MD
DEC 15 1945

1071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>		c. LENGTH OF STAY IN 1b <u>14n 22mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paint Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BENJAMIN</u> First <u>FRANKLIN THOMAS</u> Middle <u>THOMAS</u> Last		4. DATE OF DEATH <u>Jan</u> Month <u>10</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 28, 1897</u> AGE (In years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private, plus State Judge</u>	
11. BIRTHPLACE (State or foreign country) <u>Tama Co., Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>B F THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Stokes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Records of Paint Branch Nursing Home</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1956, to <u>Jan 10</u> , 1959, that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:22 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>		<u>Mt Rainier Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Transportation</u>	<u>1/10/59</u>	<u>Traer</u>	<u>Iowa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Maryland.</u>		24a. REC'D BY REGISTRAR <u>JAN 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]		PLACE OF BIRTH [Faint handwritten place]	
OCCUPATION [Faint handwritten occupation]		MARITAL STATUS [Faint handwritten status]		COLOR [Faint handwritten color]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
CITY [Faint handwritten city]		COUNTY [Faint handwritten county]		STATE [Faint handwritten state]	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01069

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights		c. LENGTH OF STAY IN 1b 18 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4548 Porter Avenue		e. STREET ADDRESS 4548 Porter Avenue	
3. NAME OF DECEASED (Type or print) Maggie Thompson		4. DATE OF DEATH January 29, 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 60 yrs.
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 30, 1959	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL CREATION, REMOVAL (Specify) Removal	
22b. DATE THEREOF 1/30/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn	
22d. LOCATION (City, town, or county) (State) D.C. Baltimore Md.		23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.-Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR DATE 5 '59		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G237 1-21-59 et

CERTIFICATE OF DEATH

01070

Reg. Dist. No.

1033

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL or town) Chesver				c. LENGTH OF STAY IN IB 22 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary First Thompson Last				4. DATE OF DEATH Jan. 15 Day 15 Year 59			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 1, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 1 Days 15 Hours 19 Min.		IF UNDER 24 HRS. Months 1 Days 15 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Neal				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Pulmonary embolism DUE TO (b) Arterio sclerosis of disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 23 , 19 58 , to Jan. 15 , 19 59 , that I lost the deceased alive on Jan. 15 , 19 59 , and that death occurred at 9:25 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Rosson MD.				ADDRESS (Street, city or town, state) 5304 Annapolis Road DATE SIGNED 1/15/59			
PHYSICIAN'S NAME (Type) William D. Rosson MD.				Bladensburg Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-59		22c. NAME OF CEMETERY OR CREMATORY Lincoln cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Washington ADDRESS San-467-71st NW.				24a. REC'D BY REGISTRAR JAN 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

John Ford

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01072

CERTIFICATE OF DEATH

Reg. Dist. No.

1034

1. PLACE OF DEATH o. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
c. LENGTH OF STAY IN lb 6 Hours		d. STREET ADDRESS 7317 Cedar Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William K Trussell		4. DATE OF DEATH Month Day Year January 31 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1885
9. AGE (In years lost birthday) yrs. 73		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Coca-Cola Employee		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hubert H. Trussell		14. MOTHER'S MAIDEN NAME Fanny Mae Royston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 32 8106	
17. INFORMANT Mrs. Ruth H. Geiman, 7317 Cedar Ave. T.P., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pul. Cong + edema + bronchitis 570.5 DUE TO (b) Intest. Obstruction due to Adhe. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-30 , 19 59 to 1-31 , 19 59 , that I last saw the deceased alive on 1-31 , 19 59 , and that death occurred at 6:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George J. Hageage M.D. 3717-38th Ave. Cottage City, Md. 1-31-59			
ACTUAL SIGNATURE George J. Hageage		PHYSICIAN'S NAME (Type) George J. Hageage	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Leesburg Cemetery		22d. LOCATION (City, town, or county) (State) Leesburg Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St NW DC		24a. REC'D BY REGISTRAR DATE FEB 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

103



The form contains several sections for recording death information, including:

- DECEASED:** Name, age, sex, race, date of birth, date of death, place of death.
- CAUSE OF DEATH:** Immediate cause, underlying cause, manner of death.
- REPORTING PHYSICIAN:** Name, address, telephone number.
- REPORTING OFFICER:** Name, title, address, telephone number.
- LOCAL HEALTH OFFICER:** Name, address, telephone number.
- DATE OF REPORT:**
- SIGNATURE:** A line for the reporting officer's signature.
- STAMP:** A rectangular box for a date stamp.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b Transient		d. STREET ADDRESS Saint Elizabeth's Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lanham Severn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Douglas Middle Thweatt Last Thweatt		4. DATE OF DEATH Month January Day 23 Year 1959	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 25, 1905
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 00 Days 00	IF UNDER 24 HRS. Hours 00 Min. 00
10a. USUAL OCCUPATION (Give as during most of working life, even if work done at home) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME David Thweatt	
14. MOTHER'S MAIDEN NAME Bertha Peoples		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Alvenia Ellis Address 5030 Mead St N E Washington D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/27/59		22b. DATE THEREOF 1/27/59	
22c. NAME OF CEMETERY OR CREMATORY Zion Church		22d. LOCATION (City, town, or county) (State) Petersburg Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Hoffman ADDRESS 909 - 4 St. N. W.		24a. REC'D BY REGISTRAR JAN 27 '59 DATE	
		24b. REGISTRAR'S SIGNATURE C. L. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2202 Chuvosty

01071

1083

VS A1S (4)
ISM 9/SB

CERTIFICATE OF DEATH

1083

1. Name of deceased *John J. Smith*
2. Sex *Male*
3. Age *45*
4. Date of death *Jan 15 1912*
5. Time of death *10:30 AM*
6. Place of death *Home*
7. Cause of death *Myocardial Infarction*
8. Duration of illness *2 days*
9. Name of physician *Dr. J. H. Jones*
10. Name of informant *John J. Smith*
11. Signature of informant *[Signature]*
12. Signature of physician *[Signature]*
13. Date of certificate *Jan 16 1912*
14. Name of registrar *[Signature]*
15. Name of coroner *[Signature]*

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01073

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1035

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5604 56th Avenue	
3. NAME OF DECEASED (Type or print) Elmer Lawrence Vennerdrow		4. DATE OF DEATH Month January Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-97
9. AGE (in years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY US Dept. Agriculture	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Vennerdrow		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W. 1		16. SOCIAL SECURITY NO. G10 E. Vennerdrow; same as # 2.	
17. INFORMANT G10 E. Vennerdrow; same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812 x DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of pelvis and comp. comm. fracture of right leg. (c) of right leg.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A pedestrian; struck by an automobile.	
20c. TIME OF INJURY Month, Day, Year 7.00 o. m. 1-21- 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) E. Riverdale Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED January 22, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/1959	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JAN 26 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. ...			

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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502 *Reviews*

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 973 1 FilmG238 1-29-59 et
 CERTIFICATE OF DEATH

01074

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Home"</u>		d. STREET ADDRESS <u>5815. Chillum Gate. Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE. MAY WATERS</u>		4. DATE OF DEATH Month Day Year <u>Jan. 15. 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April. 1. 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmund. Allen. Waters</u>		14. MOTHER'S MAIDEN NAME <u>Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emmet. R. Waters. 5815. Chillum. Gate. Rd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE ANTERIOR MYOCARDIAL INFARCTION</u> DUE TO (c) <u>GEN. ARTERIOSCLEROSIS & CORONARY INVS.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 HOURS</u> <u>12 HOURS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11. 10. 1958</u> to <u>15. JAN. 1959</u> , that I last saw the deceased alive on <u>15. JAN. 1959</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry R. Wolfe</u>		M.D. <u>905 SHERIDAN ST. HYATT</u>	
PHYSICIAN'S NAME (Type) <u>H. R. Wolfe</u>		DATE SIGNED <u>1/15/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat.</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee. Funeral. Home. 300. 4th. st. N E.</u>		24a. REC'D BY REGISTRAR <u>JAN 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1036

CERTIFICATE OF DEATH

Reg. Dist. No.

01075

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>8 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Beland Memorial Hosp</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Michellville</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>Box 52 Rt 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosie G</u> Middle <u>Weaver</u> Last <u>Weaver</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1892?</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Forsythe</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>1</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-7700</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>General arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>undetermined</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 24</u> , 19 <u>59</u> , to <u>Jan 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 24</u> , 19 <u>59</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin MD</u>		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u>	
NAME (Type) <u>L W Malin MD</u>		DATE SIGNED <u>Jan 25 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home Mt. Rainier Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

CERTIFICATE OF DEATH

1938

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1938</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF JURY <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>		27. SIGNATURE OF JURY <i>John Doe</i>	
28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JURY <i>John Doe</i>	
34. SIGNATURE OF JURY <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>		39. SIGNATURE OF JURY <i>John Doe</i>	
40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF JURY <i>John Doe</i>		47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>		51. SIGNATURE OF JURY <i>John Doe</i>	
52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>		57. SIGNATURE OF JURY <i>John Doe</i>	
58. SIGNATURE OF JURY <i>John Doe</i>		59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>		63. SIGNATURE OF JURY <i>John Doe</i>	
64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>		69. SIGNATURE OF JURY <i>John Doe</i>	
70. SIGNATURE OF JURY <i>John Doe</i>		71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF JURY <i>John Doe</i>		77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
82. SIGNATURE OF JURY <i>John Doe</i>		83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>		87. SIGNATURE OF JURY <i>John Doe</i>	
88. SIGNATURE OF JURY <i>John Doe</i>		89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

TO BE FILLED BY A PHYSICIAN OR A CLERK OF THE COURT IN THE CASE OF A DECEASED PERSON WHOSE DEATH WAS CAUSED BY A DISEASE OR INJURY.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01076

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3½ days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5004 W. Lanham Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Amos Last Weaver				4. DATE OF DEATH Month January Day 23 Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 7, 1881	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George A Weaver				14. MOTHER'S MAIDEN NAME Mary Annandale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Effie H Weaver Address Lanham, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 9040 DUE TO Gas gangrene Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured femur DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home			
20c. TIME OF INJURY Month, Day, Year 6.30 a. m. 1-20-59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Lanham Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 24, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				24a. REC'D BY REGISTRAR JAN 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEATH DUTY

NATL'G & STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Prison records

Prison records

Prison records

Prison records

Prison records

Prison records

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Prison records

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01077

1038

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Hospital</u>		d. STREET ADDRESS <u>14208 Newark Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Weekley James</u> First <u>H</u> Middle <u>Weekley</u> Last		4. DATE OF DEATH <u>Jan. 5</u> Month <u>5</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationery engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Government</u>	11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Oliver Morton Weekley</u>	
14. MOTHER'S MAIDEN NAME <u>Laura White</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>	
16. SOCIAL SECURITY NO. <u>225101567</u>		17. INFORMANT <u>Mary H Weekley</u> Address <u>Colmar Manor, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cardiac Arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Artimo Scl. 14th dec. with old myo. infarct.</u> DUE TO <u>infarct.</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>59</u> , to <u>1-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-5</u> , 19 <u>59</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David S. Clayman</u> M.D.		ADDRESS (Street, city or town, state) <u>6411 Baltimore Ave. Riverdale, Md.</u>	
DATE SIGNED		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. David S. Clayman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 1912

CERTIFICATE OF DEATH

WILLIAM F. BROWN

Male

White

Single

Married

Widowed

Divorced

Other

Age

Sex

Color

Marital Status

Occupation

Place of Birth

Date of Birth

Place of Death

Time of Death

Cause of Death

Signature

Witness

Registrar

Physician

Coroner

Other

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01078

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1039

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 16 Mo. 21 Days 41		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 513 8th Street				d. STREET ADDRESS 513 8th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roy Ignatius White				4. DATE OF DEATH Month January Day 15 Year 19 59			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-27-57		9. AGE (in years last birthday) 1 yrs.	IF UNDER 1 YEAR Months 1 Days 15	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LeRoy Morgan				14. MOTHER'S MAIDEN NAME Evelyn Geraldine White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mother; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Smothering in bed cloths. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute otitis media.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased found at foot of bed, covered by bedcloths.					
20c. TIME OF INJURY Month, Day, Year A.M. 1-15- 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Laurel Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 17/59		22b. DATE THEREOF Jan 17/59		22c. NAME OF CEMETERY OR CREMATORY Becons Chapel		22d. LOCATION (City, town, or county) (State) Anne Arundel to Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgley Selby 1200 Snowden Pl				24a. REC'D BY REGISTRAR JAN 19 '59		24b. REGISTRAR'S SIGNATURE Arthur J. [unclear]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1074

CERTIFICATE OF DEATH

Reg. Dist. No.

01079

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.				c. LENGTH OF STAY IN 1b 33			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4305 51th Street				d. STREET ADDRESS 4305 51th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Annie Middle Matilda Last Womersley				4. DATE OF DEATH Month Jan Day 2 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 6, 1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84		IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min. 84			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Louis Allison				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Alfred Chroniger Address Bladensburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Cause of Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 151X DUE TO Cause of Stroke (c) 151X DUE TO Cause of Stroke							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 151X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-2 , 19 58 , to 1-2 , 19 59 , that I last saw the deceased alive on 1-2 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 GALLATIN ST. DATE SIGNED 1-2-59							
ACTUAL SIGNATURE Aaron Deitz M.D.				PHYSICIAN'S NAME (Type) AARON DEITZ, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/6/59			
22c. NAME OF CEMETERY OR SEPTICUM Arlington National				22d. LOCATION (City, town, or county) (State) Hyattsville, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				24a. REC'D BY REGISTRAR JAN 7 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. K...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		COLOR [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF MEDICAL ATTENDANT [REDACTED]	
SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01080

1040

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>5 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>5401 Taylor Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Xydas</u> Last <u>Xydas</u>				4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/7/1890</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>		IF UNDER 24 HRS. Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Greece</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Steve Xydas - 5401 Taylor Road Riverdale, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac insufficiency</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>year</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>401 Main St.</u>	
20f. (City or town) <u>Laurel, Md.</u>				(County) <u>Prince Georges</u>		(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Jan. 1, 1959</u> , 19 <u>59</u> , to <u>Jan. 5, 1959</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 5, 1959</u> , 19 <u>59</u> , and that death occurred at <u>7:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. John Russell Buell</u>				ADDRESS (Street, city or town, state) <u>401 Main St. Laurel, Md.</u>		DATE SIGNED <u>1/6/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. John Russell Buell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>				ADDRESS <u>2901 14th St., N.W. Washington, D.C.</u>		24. REC'D BY REGISTRAR DATE <u>JAN 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

